Thursday, 9 January 2025

(9.30 am)

LADY JUSTICE THIRLWALL: Mr De La Poer.

MR DE LA POER: My Lady, our first witness today is Tracy Bullock. I wonder if Ms Bullock would be kind enough to come forward, please.

LADY JUSTICE THIRLWALL: Please.

MS TRACY BULLOCK (sworn)

Questions by MR DE LA POER

LADY JUSTICE THIRLWALL: Do sit down. Yes.

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

A. Tracy Ann Bullock.

Q. Ms Bullock, is it correct that on 29 May of last year, you provided to the Inquiry a witness statement?

A. I did, yes.

Q. And is the content of that statement true to the best of your knowledge and belief?

A. It is, although I have just spotted one error on page 4 and paragraph 17 and it states that my employment was from 1999 to 2004 at Bolton Hospital, it should be 2002. It is correct on previous pages.

Q. Thank you very much for that correction. But for that, is the content of the statement --

A. It is.

Q. -- true to the best of your knowledge and belief?

Thank you very much indeed. We will briefly introduce you by way of beginning your evidence and I am just taking this from the first three or four paragraphs of your statement.

Did you begin training as a nurse in 1984 and subsequently qualify in 1987?

A. I did, yes.

Q. Did you then hold a number of nursing positions, including positions of nurse management?

A. Yes.

Q. In 1999, did you become the Clinical Risk Manager at Bolton Hospital?

A. I did.

Q. In 2002, did you join a newly formed national team as the Associate Director within the Modernisation Agency and subsequently the Department of Health?

A. I did.

Q. And covering a period of nearly two decades from 2000 through to 2019, did you also hold at various times a seconded role with either the Commission for Healthcare Improvement, the Healthcare Commission, or the Care Quality Commission?

A. I did, yes.

Q. In terms of your main job, did you join the Mid Cheshire Hospitals NHS Foundation Trust in 2006 as the Director of Nursing and Patient Experience?

A. Yes, I did.

Q. And did you subsequently become the Chief Executive of that Trust from October 2010?

A. Yes.

Q. And just to conclude your career, following that, were you employed at the University Hospital of North Midlands NHS Trust as the Chief Executive there?

A. I was, yes.

Q. And just to give us the dates, when did you move from Mid Cheshire to North Midlands?

A. I started on 1 April 2019.

Q. And did you continue in that role until your retirement on 30 June of 2024?

A. I did, yes.

Q. And in fact, some 12 days before that retirement date, did that mark 40 years of work in the NHS?

A. It did, yes.

Q. Now, in terms of what we are going to deal with in your statement, the first thing I would like to ask you about is your experience and knowledge of the

Clothier Report which you deal with at paragraph 19. Now, was that a report that you were aware of at around the time that it was published?

A. No, no, I became aware of that when I became the Clinical Risk Manager.

Q. I am so sorry, I am sure it must be me: can I just ask you to keep your voice up, it is a very large room?

A. Yes, sure.

Q. Approximately what date was that?

A. So probably in 2000, early 2000 when I was into the role of a Clinical Risk Manager, I went to network meetings with other Clinical Risk Managers and this was a new role at Bolton, there was no predecessor, no way of doing that role so I had to learn from other people who were already doing that role in, in the NHS organisations and this was one of the reports that was particularly mentioned to me.

I was unfamiliar with it at the time and wasn't aware that Bolton Hospital at that time had done anything in relation to that report so I sought it out and read the report.

Q. And what were the main takeaways for you from that report?

A. I think the main things for me were culture,

around safety and around making sure that staff were competent and that there were checks on what staff were doing and sufficient training and resource for staff. I think -- it was a long time ago, but for me at a high level they were the key takeaways, I would say.

Q. One of the recommendations of the report was the importance of a continued memory of the fact that a person may be acting malevolently causing harm to patients, which of course is exactly what Beverley Allitt did?

A. Yes, yes.

Q. Was that something that came out of your reading of the report and your understanding after that?

A. Yes. It certainly came out in the report and I do vaguely recall it coming out. But it is something that fortunately happens so infrequently and you don't imagine it happening in your organisation, with your staff, so it's not something that really was at the forefront of -- obviously there were things that were put in place around governance and safety in a way to try to mitigate those things, but it wasn't something that was at the forefront, should I say.

Q. I am paraphrasing here but it may be thought that one of the things that Sir Cecil was trying to communicate when he made that recommendation was exactly

the point you are making?

A. Yes.

Q. This is an extremely infrequent occurrence?

A. Yes.

Q. The fact that it is infrequent makes it all the more important that people remember, because otherwise the lack of frequency means that it just drops out of your thinking?

A. Yes.

Q. So do you think that it did drop out of your thinking having read it or do you think that you managed to hold on to that idea and applied it when confronted by relevant situations?

A. I think where -- where it remained in my thinking and where it was applied was in terms of the induction that I gave for staff. So I made sure that reference to patient safety, recognising each other's limitations, you know, and that some people might be acting outside of the limitations and making sure that governance and speaking up processes were robust.

So I think it was -- it was more in the training and induction of staff where I used that.

Q. Do you have any recollection of any incident after 2000 which you were asked to consider or which you came across where you consciously thought: I just need

to make sure that there isn't deliberate harm being caused here?

A. Yes. There have been a number of incidences throughout my career where perhaps I have been in a situation where we have seen, as with this case, a higher mortality rate in a service and one of the things that we have done as a result of that is an immediate scope of that service, a review of all the quality parameters of that service, a listening exercise with the staff to understand what's going -- what's happening in that service and if they were aware of higher mortality rates.

So yes, there's been numerous events like that. Fortunately there has always been a reason for it or an explanation for it.

Q. We will come to the degree to which it was in your thinking in any conversations you had in 2017 in just a moment. But at your paragraph 22, you respond to a question posed by the Inquiry about when a member of staff's conduct towards a child should be reported to the police?

A. Mmm.

Q. I just want to explore that briefly with you --

A. Yes.

Q. -- in terms of your experience of it. Have you yourself ever been involved in a situation where you have felt it necessary to contact the police arising out of the actions of a member of staff?

A. Yes.

Q. In terms of who you would expect to be notified, you list a number of organisations and I just want to be clear about when in the timeline that they ought to be notified and I will just identify those organisations, the CQC, Integrated Care Board, Chief Nurse and Chief Executive, Chief Executive of NHS England Midlands or the region that the hospital is in, and then the police if appropriate.

So those are a number of organisations that you regard as needing to know. Is that all as a piece when you go to the police or are there stages along the way where before you get to the point where you think "we need to go to the police", you elevate the concern to an external body?

A. It depends on the seriousness. It depends on what you are being faced with and as I also allude to in, in that paragraph, things aren't always immediately obvious and sometimes you do need to do some form of scope or some form of review before you fully understand and that may then translate into understanding who you

need to go and speak to.

But in the more serious of cases we would go to, and these are not necessarily linear, you wouldn't go to the police then the CQC then the ICB. These would be done in parallel and could be done in parallel so I might ring the police, where the Chief Nurse would likely ring the CQC as she would have that relationship with the CQC, the Medical Director might take a role.

So there may be numerous -- obviously what I would wish to do under those kind of circumstances is to have a discussion with my own team, in particular the Chief Nurse, the Medical Director and, and possibly even the Chairman but perhaps that at a later date.

But then we would collectively agree who needs to be contacted based on what we know at that time and who is going to make the contact with those people.

Q. And why might it be important that those other organisations are informed?

A. I think first and foremost for transparency and to let them know that -- and they may hear things, you know, things may get into the public domain, so you would want them to know from yourself. You would want them to know that you understand what's happening in your own organisation, that you are aware of it and that you are doing something about it and that you will come

back to them at a future date.

Q. Now, I would like to turn now to Tony Chambers, please, which you deal with in your witness statement at paragraph 34 and onwards, just so that you have the page open.

A. Yes.

Q. Now, when did you first meet Tony Chambers?

A. So I can't remember the exact year but I started my nurse training in 1984 and at Bolton Hospital, Tony Chambers trained as a nurse at Bolton Hospital but some time after me and I do recall coming across him when I was a student nurse.

Q. And at that stage was it simply that your paths crossed or did you become friends or were you professional colleagues, what was the relationship at that early stage?

A. Our paths crossed, you know, as we would as students. We generally stuck with our own cohort of students, our colleagues who we were training with but our paths crossed and, and that was the relationship that we had during that time.

Q. And once you graduated and moved away from that environment, when was the next time that you saw him?

A. I think the next time that I recall seeing

Tony Chambers, I was aware that he had left Bolton and that he had gone on to do other things, I don't know, I cannot remember what that was. But the next time that I recall seeing Tony, I think I was either a junior sister or ward manager and he had come back to Bolton as a bed manager and that's when I next, so I was quite surprised to get a phone call that it's Tony Chambers here, how many beds have you got, can we use some of those beds?

Q. So again at that stage was it simply that your paths were crossing or did a friendship develop or were you just professional colleagues dealing with a professional situation?

A. I think professional colleagues but we knew each other so we would have a chat, a friendly chat, so we would ask each other how we were and what was going on in our lives. We would have friendly discussions.

Q. So you encountered him then. When was the next occasion that your paths crossed?

A. So I then left, so I used to see him in Bolton on and off and when I did I would say hello to him but then I left Bolton in 2002 and I took up a national role. That's the, after about, after a couple of years in that national role, again I can't remember the exact dates, but Tony Chambers obviously applied for --

I didn't know this but applied for and got a job in the same national team that I was working in.

So that's the next time that I saw him.

Q. And once you came to be working in the same national team, did you work together?

A. We worked together at Mid Yorkshire Hospital. But it was a national team, so you didn't work with someone all day every day. You went into do specific pieces of work for the organisation. Some of those were with Tony Chambers, actually, most of them weren't.

And Tony Chambers I think was with us, with that team for a relatively short period of time and through his work with Mid Yorkshire Hospital, he then became the Director of Operations.

Q. And again would you say that you had developed into a friendship at this stage with him?

A. Yes, I -- it was always a -- it depends how you define "friendship". Did I go out with him socially drinking? No. Did I meet him outside of work related events? No. But within work we had a friendly professional relationship.

Q. And so if we move forward please to 2017, when we know you had contact with him, what had been the most recent contact before that, would you say?

A. I would probably say at one of the regional

Chief Exec meetings, that is where I would normally come across Tony.

Q. And by this stage you are both Chief Executives?

A. Yes.

Q. Were there conversations before 2017 --

A. Yes.

Q. -- where you spoke to each other as Chief Executives?

A. Yes. Yes. There were. So firstly what I would say is when -- when Tony Chambers was applying for the role at the Countess of Chester, I became aware of that because he contacted me just to seek advice on the Cheshire and Merseyside region and Mid Cheshire's working relationship with the Countess of Chester.

So we had a number of phone calls there prior to him going for his interview. Then once he was appointed as the Chief Executive at the Countess of Chester, again I would see him regularly at the Chief Executive meetings and there would be ad hoc phone calls. If I was aware that he was doing something interesting in his organisation, or vice versa, we would ring each other to see what was happening.

If there was some new development or new policy that was national and one of us wanted a steer on what

the other was doing in relation to that in our organisations, we would perhaps have a discussion.

But that wasn't necessarily just with Tony Chambers. I would do that with a number of Chief Executives. I was a Chief Executive before Tony Chambers, so I did have a strong network of Chief Executives who I would contact if I needed if I wanted advice and support and that was a mutual relationship.

Q. So am I right in thinking that when we get to 2017, there had been a number of occasions when you had spoken as Chief Executives?

A. Yes.

Q. Whether one to one for advice or support?

A. Yes.

Q. Also in a larger group setting --

A. Yes.

Q. -- of Chief Executives.

You were at that time Mid Cheshire; is that right?

A. Yes.

Q. And he was Countess of Chester?

A. Yes.

Q. So does that mean that you were geographically extremely close in terms of the client group, the patient group, the structures that existed?

A. No. Quite the opposite, actually.

It was quite a -- there was a lot of talk at that time about developing relationships and partnerships with other organisations and Mid Cheshire was unusual because it was at the very southern end of Cheshire and Mersey. So the nearest relationship for Mid Cheshire was actually the University Hospital of North Midlands where I subsequently went to. That was nearer, it was larger, it provided the tertiary services that we would require that we didn't provide ourselves whereas the Countess of Chester was a more difficult journey, it was -- our population wouldn't easily travel there or want to go there and you have to -- when you are making decisions about who you work with as an organisation you have to consider patient choice and patients would generally choose to go to a nearer hospital rather than one much further away, specially if they don't have public transport: that would have been a very, very long journey for some of our patients.

Our patients would choose to go to the University Hospital of North Midlands so whilst we were in the same Cheshire and Mersey region we did not have a working relationship together.

Q. Now we will come to the contact in 2017 and the Inquiry has good reason to believe that the conversation that you had with Dr McGuigan was at the

end of March of 2017 and I don't think you would say that that is definitely wrong although you didn't have any reason at the time to notice the date?

A. Yes, I do not recall the date but I have no reason to believe it's not accurate.

Q. Now, by that time, the conversation you had with Mr Chambers beforehand, were you aware of the increased mortality on the neonatal unit at the Countess of Chester?

A. No, I don't believe I was.

Q. Does it surprise you knowing what you know now that particularly given the timeline, namely that all the way there was an increase between mid-2015 to mid-2016, there was then an internal review, the Royal College came in all of this in the back end of 2016, so a lot of activity around it, does it surprise you that that information hadn't reached you?

A. In some respects, no. That was internal for Countess of Chester to deal with. Tony obviously approached me at a point where he felt that he needed advice, he needed to understand if there was more that he could or should be doing and it was at that point that I -- I became aware of it.

There are national reports such as the MBRRACE where neonatal mortality rates are published but they

don't actually name the other Trusts. So whilst you can benchmark yourself and you know where you stand in relation to peers, you don't know which peers, well, you know generally the peers of similar sized organisations with similar populations, but beyond that, you don't know the names.

Q. So we will come to the contact with Mr Chambers. What form did that contact take?

A. So I have read Tony's statement or transcript from the -- which was sent to me. I recall it being a telephone call and although, you know, it was almost eight years ago and when somebody says something different you do start to doubt yourself but in my mind up until reading what Tony put in his statement, I presumed that, well, I thought that was a call. I was pretty certain it was a call.

Q. And if we just test that in this way. Knowing yourself as you do, the conversation that you had with Mr Chambers is that the sort of conversation that you would be prepared to conduct on a train?

A. You -- it would be limited, your conversation would be extremely limited. There would have to be a lot of situational awareness who is around you unless you were very, very lucky to have an empty coach or no one in that coach. It would be -- it would be

unusual.

Q. And in terms of what you remember being discussed in that conversation so your recollection of the content of the conversation, is that the sort of content that you would have been prepared to discuss in a train carriage?

A. In all honesty probably not.

Q. And so your recollection is a telephone call?

A. Yes.

Q. Was that him to you or you to him?

A. Him to me.

Q. And doing the best you can, what did he say to explain why he was calling and how did the conversation develop?

A. In essence, I don't remember the detail, but in essence, he wanted to run by me high mortality rates at the Countess of Chester Hospital. He wanted to discuss with me the things that he and the Countess of Chester, the board were doing in respect of that and whether there was anything else that I would recommend.

He also wanted to discuss with me the relationship with the paediatricians and how that relationship had deteriorated and from, from the discussion that I recall was worsening. So he wanted to seek my advice on those things.

Q. And in terms of the detail, you knew about the increase in mortality on the neonatal unit and you knew about a worsening in relationships. Did he make clear to you who, whether by role or name or number, the relationship had deteriorated with?

A. From the way he described it it sounded like it was with all of them, although he did as I have put in my statement, he did describe two Consultants who were -- these are my words -- leading the charge if you like.

He didn't name any of them and had he done I wouldn't have remembered because I don't know any of the characters in -- in Countess of Chester.

Q. Now, although you were qualifying what you just said in terms of it being your paraphrase "leading the charge", there is an emotional sense behind that phrase, namely that this is a combative experience where you have got two sides who are not collaborating but rather butting against each other?

A. Yes.

Q. Although he may not have used those the phrase that you adopted as a paraphrase, is that what he was saying, that there was a combative environment in which there was one side and two people were leading that side?

A. He, he described it as two people leading the charge, but also that the other Consultants there were firmly behind those two people. He didn't sort of say they were out on a limb and doing something that the others didn't agree with. So he, he was, but what he did describe was quite fractious meetings, some very tense meetings with the doctors and that's, that's what he described when he was talking about the worsening relationships.

Q. Now, as he was talking about the group of paediatricians, did Dr McGuigan's name come up?

A. It did.

Q. Who brought Dr McGuigan's name up?

A. I thought I had, but he may have done as well. Because at the time, when he was talking about the relationship with the paediatricians I recalled as he was having that discussion that one of our paediatricians Michael McGuigan, who was a newly appointed Consultant at Mid Cheshire, in fact I think I appointed him was part of the interview panel, and basically he had left to go and work at the Countess of Chester.

And I asked if, how Michael was and I think Tony's response was that he hadn't really spoken to Michael, he had only been there a couple of months and he basically

said, you know, is he all right? Would he be objective? what is your view on him? And I thought Tony -- I thought Michael McGuigan was very professional and would have a solid view on -- on what was going on.

Q. Now, was the police mentioned?

A. Yes. So during the discussion, Tony told me about numerous things that he was doing to look into the mortality rates. I can't remember them all now, there were about half a dozen or so things that he mentioned, one of those was the Coroner reviewing deaths, another was I can't remember whether he said it had happened or was happening, but a review by the Royal College of Paediatricians. And then there were a number of other things.

So, sorry, I have lost the thread of what your question was apologies.

Q. The question was whether the police was mentioned?

A. Yes, and what Tony said at the time was that -- I am just trying to recall what he had actually said -- that the paediatricians weren't wholly happy because none of the things that they had done to date had come to any conclusion and he felt that the paediatricians wouldn't be happy unless there was a police investigation.

Tony during that discussion did recall that he wasn't adverse to a police investigation but he just felt that those half a dozen things, those avenues should be closed and understood before a police investigation.

Q. Did Mr Chambers mention to you that the Consultants were concerned about one particular individual?

A. Yes. He did say that the Consultants were -- I can't remember what the words he used but pointing the finger at a particular nurse. But there was no indication at that time that it was intentional harm.

It was a conversation that she happened to be on shift when a number of these deaths occurred.

Q. I just want to investigate your thought process and any challenge you may have given to Mr Chambers. So you know that Michael McGuigan at the very least is a steady head?

A. Yes.

Q. Got good judgment?

A. Yes.

Q. You know that he is one of a number of Consultants who are concerned, you know that that group including Dr McGuigan want the police called and you know that that group want the police called because they

have concerns about a particular individual?

A. Mmm.

Q. And if you just pause for a moment, just putting those facts together all of which appear to have been communicated to you by Mr Chambers?

A. Yes.

Q. Doesn't that inevitably imply that the Consultants are concerned that that individual is causing harm intentionally?

A. Not necessarily. There were a lot of things that we discussed during, during that discussion and, you know, some of the things that he talked about were the team working within the department, the culture, he talked about staffing levels. You know, I think there were a number of things all of which could contribute to a high mortality rate and then if you have in my mind competency of an individual as well, that adds to that.

So at that time, at the time of the call, as he was talking to me, I was stacking things up and thinking well, we have got the teamwork, the staffing levels, we have got all those various factors, all of which could contribute to a high mortality rate so I wasn't particularly thinking this was intentional harm.

What I was thinking about is what do you need to do and how would you get to the bottom of what is actually

driving it.

Q. Forgive me, I wasn't suggesting that you were reaching any conclusion yourself for the cause but rather what other reason would this group of Consultants, including Dr McGuigan whose judgment you trust, what other purpose or reason would there be to involve the police?

A. Yes.

Q. If if wasn't that they suspected harm by that individual that they had identified?

A. Yes, yes, I would agree, yes -- yes.

Q. And so you are presented with a situation where, just focusing on Dr McGuigan, a doctor who you respect who hadn't been there long, who wasn't enmeshed in the culture, didn't bear any personal responsibility for the deaths, couldn't be thought to be trying to be defensive or covering his own position, is part of a group saying: we suspect an individual is killing babies, I mean that is the only way it can be phrased?

A. Yes.

Q. Given there is an increase in ... so that is an extremely serious thing?

A. It is, yes.

Q. And presumably a situation that you, knowing Dr McGuigan as you did, would wish to take absolutely

seriously?
A. Yes, absolutely.
Q. Did you say to Mr Chambers: look, if Dr McGuigan thinks that, I really think you need to call the police?
A. The conversation almost went around those lines because by then, as I said, there were those half a dozen or so things that had already been done and he felt that the only avenue that was left was the police and we did discuss that and you know, like I said, he wasn't adverse to contacting the police that I recall.
Q. But if the only avenue left is calling the police and that is the thing that the Consultants wants, there is no conflict, is there?
A. No.
Q. And yet your perception was that this was a situation of conflict?
A. Yes. I think from what I recall, the paediatricians wanted the police calling much sooner. They wanted it, if you like, much earlier. From, from my recollections, rather than doing those five or six things that he talked about, when they first raised the high mortality rates with Tony, I am assuming they raised it, they wanted a police investigation at that stage.

So not after they had done Royal College investigations and other reviews.
I think that's where the conflict was. That's where the tension was and I think they were getting frustrated because they were waiting whilst all these reviews happened and these reviews weren't giving them the conclusions that they needed.
Q. But if the point had been reached, if it was the point that Tony Chambers was saying to you: I am going to call the police now, that firstly that conflict is completely resolved?
A. Yes.
Q. Would you agree?
A. Yes.
Q. If that was his position and, secondly, the Consultant paediatricians would be to some degree vindicated because their point would have been what's the point of doing all the other things?
A. Yes.
Q. We need to call the police and that is where the situation has ended up?
A. Yes.
Q. So if that's right there doesn't seem to be a problem any more for the Consultants, they have been vindicated and they are about to get what they want.

But from your call to Dr McGuigan, which we will come on to, it doesn't sound like you thought the conflict had resolved or that the paediatricians were going to get what they wanted. So how do we reconcile the two?
A. Yes, not at that time.
And I think the relationships had been so damaged during that process of time that, you know, Tony -- I remember Tony speaking to me in particular about recovery of those relationships. He was, he was -- you know, he was very upset that that had happened with the relationships and even though I think they ended up going down the right route, I think it was too late for the relationships so to speak. That's my -- my view of it, not that Tony or Michael said that to me.
Q. And if we just take stock at the moment that call ended. Was it your understanding that Mr Chambers was going to call the police after that call or that there were going to be other steps that would be taken which may mean the police weren't called?
A. I think that by the end of that call I can't remember very clearly but I think that in Tony's mind he was coming to the end of the road in terms of other things and that the next step, and when that happened after that call, I don't know, the next step would be the police.

Q. So your impression was that the police would be called imminently after that call at the end of March?
A. I wouldn't, he didn't give a timeframe. He didn't give a view on that. It was just: we are nearing the end of all of these things, there's one or two things that just still need to conclude. And then, then I think the last thing that we, we have to do is, is contact the police.
Q. But it sounds as if there are other things that need to be resolved before the police are reached?
A. Yes.
Q. The conflict would in fact continue?
A. Yes, that, that was my view, is that there were still things in train and that Tony Chambers wanted to see those things conclude. I think I might have written that in my statement he wanted to see things conclude before he contacted the police.
Q. And does that mean, before we move on to Dr McGuigan, that there was a possibility the police wouldn't be called because the outcome of those outstanding things would -- may mean that the police weren't necessary?
A. Yes. If, if one of those reviews brought a conclusion that satisfied everyone, including the

paediatricians, then it may not be necessary to call the police.

Q. Now, as you move from the conversation with Mr Chambers to that with Dr McGuigan I just want to examine your state of mind. At any point in the call or immediately afterwards, did the case of Beverley Allitt come to mind?

A. No, not, not particularly in relation to that discussion. That's not what was in my mind at that time.

Q. Because you had all the features there, didn't you, that might prompt it, you had the fact that there was an individual, as it happened a nurse?

A. Yes.

Q. The fact that they were concerned that it was babies being killed?

A. Mmm.

Q. That the Clothier Recommendation that it needed to be at the forefront of mind would this be, fair to say, didn't in fact eventuate in your mind, at this time?

A. I mean Tony, you know, Tony did allude to whether or not she could be intentionally harming and he didn't feel that, at that stage, that the evidence was saying that.

Q. Did you have any thought to the importance of a police investigation starting as soon as possible in order to ensure that evidence isn't lost and memories don't fade?

A. From the outside looking in, and you know, knowing what we know now it's easy for me to sit here and say, yes, I would have done a police investigation and I would have done it sooner.

Q. Forgive me, I wasn't asking what you would have done in Tony Chambers's shoes?

A. Yes.

Q. I was asking your state of mind in that call and immediately afterwards, did it cross your mind: well, look, this has obviously been going on for a long time now the mortality increase?

A. Yes.

Q. In fact, had passed by nearly nine months?

A. Yes.

Q. There is an urgency to this now if we got to the point where the police are a really serious option we should be going down that route?

A. Yes.

Q. Did that cross your mind at all?

A. Yes, and -- and, you know, I am sure that that was part of the discussion that we had, you know,

discussing all of the factors that may be contributing to it and -- and as I said, he was of a mind that the police were, you know, was, was the next port of call.

Q. So we come to the conversation you had with Dr McGuigan.

A. Yes.

Q. How soon after your conversation with Mr Chambers was that?

A. I think it was relatively soon.

Q. Same day?

A. No, no, I -- I think it was it took a couple of days for me to get around to ringing him. I think I would say it was within a couple of days.

Q. Did Mr Chambers know that you were going to contact Dr McGuigan?

A. Yes. At the end of the discussion, I did ask Tony how Michael McGuigan was and he said he didn't really know him as he had only been in the organisation for a few months and I asked if he would mind if I contacted him just to see how he was.

I think my intention at that time was not necessarily for me to contact him personally but to speak to one of our paediatricians who knew him better to actually contact him. But then after on reflection, knowing this was sensitive, confidential, I didn't

necessarily want to speak to one of our paediatricians about it, so I made the call myself because I did know Michael from interviewing him and I remember doing some leadership development with him.

So, you know, I did get to know Michael a little bit, so I didn't feel any qualms about ringing him and doing a welfare check. And I got my PA to ring his and a meeting, a call, it was a phone call, was arranged I think a couple of days after the call with Tony Chambers.

Q. As we did with Tony Chambers, what did you say to start with, how did you introduce the call and what did you say subsequently?

A. So, so basically, I think I started off with, you know: how are you, how are things going? Recognise things are difficult. I did tell him that I had had a phone call with Tony Chambers a couple of days ago and that Tony had told me about the high mortality rates and the difficult relationship with the paediatricians and that things were quite tense between clinicians and management and I just wanted to know how you were. Are you okay? How are things going, do you need to speak to anyone? Happy for you to speak to me but might be better for you to speak to some of your paediatricians but do you need anything? That was, that was nature of

the call and then we did get on to discussing some of what was going on. Although Michael was very not withdrawn but he wasn't particularly forthcoming, he was very professional, he wasn't forthcoming. I think he, he didn't want to say anything that he felt he shouldn't say.

So the conversation was quite brief, quite friendly and that's as much, that is pretty much how it went.

Q. Now, I would just like to take you through Dr McGuigan's account of that conversation --

A. Yes.

Q. -- so that you can comment upon it.

And for this we need on screen, please, INQ0001985. This is a statement that you ran through, were provided with when you gave your witness statement and you have made comments on already. Obviously we have had heard Dr McGuigan's evidence as well but let's go to page 14, please. We see it is an account he gave to the police in May of 2019.

Forgive me.

A. Yes.

Q. We can see that at the top there the call to set it up and he begins by indicating that you explained, I am looking at the first paragraph here, that you were a personal friend of Tony Chambers?

A. Yes.

Q. And that as Chief Executive in a Trust they would talk about what was happening in organisations, bounce ideas off each other. So in terms of the "personal friend of Tony Chambers" is that something you think that you would have said?

A. I think what I may have said is, I don't recall whether I said that or not, I think I would have most likely said "I have known Tony for a very long time" and I think what I was trying to do was justify why Tony Chambers would ring me and disclose sensitive and confidential information which it seemed to be -- very much seemed to be at that time.

Q. He goes on to say that you told him that you were aware of what was happening within the Countess at the time and had suddenly realised that he was working there and potentially now found himself in a very tricky position. Again --

A. That's correct, yes.

Q. -- does that accord with your recollection of the sort of thing that you might have said?

A. Yes, absolutely yes.

Q. I know that you say in your witness statement you don't recognise some the phraseology here --

A. Yes.

Q. -- but it is the substance that we are interested in.

A. Yes.

Q. Now, he records that you reported that your understanding was that there were clinical issues at the neonatal unit and the paediatricians were refusing to accept these clinical issues and trying to pursue another explanation for problems that had been happening on the neonatal unit.

So do you think that's the way in which you will have characterised what you understood the problem to be?

A. I don't think that is the way I would have portrayed it to to Michael McGuigan because that is not how I understood it at that time. I didn't understand what the clinical issues were at that time. There just wasn't enough detail that Tony gave me to make that kind of understanding.

So I -- I don't know, I think, I think probably the discussion that I was trying to have with, with Michael was: have all avenues been explored? Have we considered everything? You know, as well as individuals? And he felt that they had.

Q. Now, they were now pushing for a police investigation so you knew about the fact that

Consultants wanted a police investigation?

A. Yes, yes.

Q. And then this: her understanding was there were two particular leaders of that refusal to accept the clinical issues on the unit and pushing for an alternative explanation and things were going to end badly for those two leaders.

Again just pausing there I know there is a bit more that we will need to look at, you knew that there were two particular Consultants leading the charge?

A. Yes.

Q. That paraphrase?

A. Yes.

Q. What about the rest of it?

A. Yes.

Q. The refusal to accept clinical issues and that things were going to end badly for those two leaders.

A. Yes. I don't recall that being said, that I said that to Michael McGuigan, I don't recall Tony saying that to me.

The type of conversation that I most likely had with Tony is about when, when relationships between managers and clinicians break down, things do usually end up badly and that "badly" is in terms of staff morale, poor outcomes for patients, you know, there is

a lot of research out there that, that basically says that where there's poor teamworking, there is poor outcomes and that was probably more likely what I was trying to get to with Michael.

Q. So "end badly" might also mean that the management decide that they need to move the staff out of the organisation, "end badly" might mean being referred to their regulator. Did you mean to imply --

A. No.

Q. -- either of those?

A. No, the "end badly" was about bad outcomes for patients.

Q. "She was concerned I was going to get caught up in it and my reputation would be brought down along with those other paediatricians."

Again, do you think you gave Dr McGuigan the impression that his reputation would be tarnished by his involvement in the situation?

A. I think I was very clear with Michael about being his own person. He had only been there a short period of time, he could be objective. He could make his own view. And basically I said: just make sure you have explored everything, that you are your own person and that you make your own decisions about what you think is right or wrong.

He felt that he wholly supported the paediatricians and their views that they had got on the matter at hand. He was very much behind them on that. And the other, in terms of the well-being he, I was left with the impression that he felt safe.

Q. Now, if we just examine what you have just said, your recollection of what you said to him is mainly that he ought to be his own man?

A. (Nods).

Q. That is rather the opposite of what Dr McGuigan appears to be suggesting you were saying because it might be thought that you are expressing concern he was going to get caught up in it was rather suggesting that instead of being his own man, he needed to get out of the situation?

A. No, I wasn't saying "get out of it". I was just saying, you know, because this is -- so what I was saying to him was, you know, don't just follow like sheep. Be certain that you have seen, that you are certain yourself what the issues are and what he described to me was that I am, I am certain, you know, we have discussed this at length. We have looked at various things, I do believe that the paediatricians in the unit are right.

So that, that was the way the discussion went.

Q. Why would you say "don't just follow like sheep"?

A. Sorry?

Q. Why would you say "don't just follow like sheep" to Dr McGuigan?

A. I just remember he was a relatively junior Consultant. He was going into a team of what I believed were quite senior, experienced Consultants who had already formed a view. What I was saying to him is make your own mind up. And he felt, he felt he had done that reflection. He felt he had had those discussions and he felt he had come to a conclusion for himself and that he was satisfied with the conclusion that he had come to.

Q. Now, the next paragraph, mention of an email of his. Now, we know that an email of his was discussed at a meeting. What he records in the statement is:

"She had heard that an email from me had been read out in that meeting on the Monday pushing for a police investigation. She was concerned for me that my reputation would be brought down along with the other paediatricians in the Trust."

A. Yes.

Q. Firstly, we have covered the second part of it, we don't need to go over that, but what about this email?

A. I don't recall a discussion about an email with either Tony Chambers or Michael McGuigan. That doesn't mean to say it didn't happen. But I don't, I don't particularly recall it and, and, you know, the statement from Michael has been a prompt for me in terms of recollecting some of the discussion from previously but that isn't a recollection that I make even with him stating it in this statement.

Q. If we go over the page we can see he records in the first substantive paragraph that the call was slightly awkward. Is your recollection that it was an awkward or slightly awkward conversation or did it not seem that way to you?

A. Yes, certainly not for my part but I could tell that Michael felt it was awkward. He was, he was very, very guarded in terms of what he was saying and in many respects said very little.

Q. We can see his response has two parts. The next but one sentence:

"My response it was hard being part of something serious within this new organisation where I don't know people."

I think we have already covered your discussion around what you were telling him about that?

A. Yes.

Q. It is the second part I wanted to just cover with you. Next paragraph:

"My other response was that I didn't feel I was working with a bunch of people who were ignorant and had got themselves on the wrong agenda but that I had a lot of confidence with the people I was working with."

A. Yes.

Q. "That this wasn't just the opinion of two people, but everyone was concerned in a similar way."

A. Yes.

Q. "I had confidence in my colleagues and they were trying to do right thing in a difficult situation."

A. Yes.

Q. Do you recall him saying that to you?

A. Yes. Yes. And that was part of the discussion about, you know, where he said he had formed his views, he had been his own person, he had had a look at it, he had had discussions and that is the conclusion that he came up to.

Q. We have covered what he recalls being said?

A. Yes.

Q. Obviously, sub text is also important, the implication of what is being said?

A. Yes.

Q. When you add up all the different things that

everybody chooses to talk about?

A. Yes.

Q. This is what he says about the implication. Next paragraph:

"The implication of what she was saying is that the paediatricians should be recognising the faults within themselves and their department and addressing them and that because they are egotistical, selfish or in denial this they were trying to push the problem on to someone else, that they are bad people who are heading for a downfall."

So that is not him saying you said any of those things, so we will be clear about that?

A. No.

Q. As is obvious from the fact that he says "the implication" but that is what he is saying he took away from what you said?

A. Yes.

Q. Do you think that is a reasonable implication for him to draw?

A. I don't recall really recognise much of that, in all honesty. And, you know, I have tried to think about how he might have formed those impressions and I think that may have been the discussion about exploring all avenues, that is all I can put it down to.

You know, making sure that all avenues were explored, that, you know, that things, you know, it could be individuals, it could be people, it could be team working. We talked about team working and the impact on outcomes and that was much of the training that I used to give at Mid Cheshire especially with Consultants.

I don't recognise it coming across as starkly as, as what Michael has written in the statement there.

Q. Well, if we just put together some of the things that you recall.

A. Yes.

Q. Starting the conversation by saying you have known Tony Chambers for a long time might tend to suggest that you admired, respected him, liked him, had no reason to think that he would be wrong about it and of course he is on the opposite side of the dispute?

A. Yes.

Q. So might that give the impression that you are here acting on Tony's behalf or trying to support him in the dispute?

A. I actually I believe started the discussion by saying: this is a phone call that I asked Tony if I could make. I am not ringing because of him. So I do recall being very clear about that. This was, this is about seeing how you are, Michael.

In some respects I was being a little bit nosy. Tony had given me a version of events and in some respects I was trying to know more from Michael, see if there was anything different there. I didn't particularly get that. And I think Michael knows -- I think knew me well enough to know that I wouldn't be making that kind of discussion, whilst I did respect Tony or do respect Tony, and, you know, I have known him a long time, I also respect Michael and respect very much Michael's views.

Q. If we just pick out another thing. You revealed to him that you knew that there were two people leading the charge?

A. I did.

Q. Which might be thought by some as Mr Chambers having revealed quite a lot about the dynamics of the dispute and the fact that they were two people who he had identified as being particularly responsible for the conflict?

A. Yes.

Q. So again do you recognise that that might cause a person hearing that to think: gosh, Mr Chambers is talking to his friends about two particular doctors who are causing the problem?

A. Yes, absolutely. And -- and he was very clear

to me it wasn't just the two.
Q. Well, that was his perspective?
A. Yes.
Q. But that is what he was --
A. Yes.
Q. He understood that Mr Chambers ... and by telling him to "be his own man" again this is your recollection, do you see that a person might take from that that what you are saying is: you have made the wrongdoings, I am worried you are being a sheep, you need to be more objective?
A. I don't think Michael saw it as that. It was -- it wasn't that kind of discussion, it was a very friendly discussion, it was quite light and it was just you know, just please be your own person and we just had a discussion around the events and it didn't, it wasn't like that you know, and he was quite content with where he had got to in terms of his thinking.
He didn't feel, you know, under pressure from that end, from the Countess of Chester end. He felt he had made his own decision on things and where things were up to.
Q. Well, he's described the implication. You are right to draw attention to how he concluded the conversation?

A. Yes.
Q. We will just read it into the record there:
"I did not feel any pressure from that phone call or that she was calling me to tell me to shut up. It was purely that she was concerned that I was in a tricky position, wondering if I was making the wrong judgment calls and warning me about how it might be seen by other people. It was purely a friendly call to tell me to be careful about the situation."
A. Yes.
Q. I think you say in your witness statement that while you don't recognise the implication that he has recorded --
A. Yes.
Q. -- that he reached, that that is your perception of the call?
A. Yes, pretty much, yes.
Q. Now, having had this call with Dr McGuigan and he having been, if this is fair, adamant that he has chosen the right side of this conflict, that he believes in his colleagues, that it isn't a question of one group being led by two charismatic figures but this is a body of opinion, bearing in mind you knew that the body of opinion was: the police need to be called immediately because we are worried an individual is killing babies,

did you then call Tony Chambers to say: I have spoken to Dr McGuigan, he absolutely isn't being a sheep here. He's got good judgement. You must call the police?
A. I didn't. I didn't ring him back after the call but I know I will have spoken to Tony about it perhaps when I saw him at a meeting and that meeting likely happened soon after, you know, I wouldn't have let that drift on. Yes.
Q. But bearing in mind that this was a patient safety issue --
A. Yes.
Q. -- do you think you should have called Mr Chambers back immediately to say: look, I can give you a particular insight into Dr McGuigan that you just don't have. He believes it. He's not being a sheep. You need to call the police immediately. Do you think that's something you should have done?
A. On reflection, you can say yes, possibly it is something that I should have done. But in my mind at that time, Tony was going to call the police. She wasn't -- Lucy Letby wasn't working in a clinical environment at that time so in terms of immediate safety concerns, there weren't any.
Q. Did you know anything about the discussions about returning her to work?

A. No.
Q. And do you think that's something you should have been told if there were discussions about returning her to work at the time you spoke to Mr Chambers?
A. Tony would have no reason to tell me that kind of thing at all apart from seeking advice. In my mind, that is the kind of discussion that I would likely have with a Chief Nurse, maybe even NHS England, maybe even CQC. That -- Tony had no obligation to tell me about that.
Q. No, but it seems he did tell you that she wasn't working?
A. Yes.
Q. And so that's one piece of the puzzle?
A. Yes.
Q. But if it's also the case she's not working but there is a plan to return her to work, if that's the case, would you have expected him to tell you that second piece of information because otherwise the first piece of information may be thought to be misleading?
A. Yes, yes, unless he didn't know at that time and I don't know.
Q. No, well whether or not, but I am asking in the hypothetical, that if that was the plan as at the time of your conversation --

A. Yes.
Q. -- would you have expected to be told that as part of the "she isn't working at the moment"?
A. Yes, possibly. If he was telling me she wasn't working then he may, may or could have gone on to say: but we are thinking of bringing her back.
Q. Because it seems to have informed your thinking, because you have told us the reason you didn't immediately phone him was because you thought that there was no immediate risk to patient safety?
A. Yes, yes.
Q. So the fact you didn't know that, if that is true --
A. Yes.
Q. -- would be important to you?
A. Yes.
Q. Just to conclude this piece. You say that you spoke to Mr Chambers subsequently?
A. Yes.
Q. Did you discuss with him your conversation with Dr McGuigan or the situation that he had phoned to seek advice from you about?
A. Yes. So following that phone call, I will have seen Tony on a number of occasions, again at the Chief Exec meetings, and, and I would always speak to

him. It, it wasn't specific discussions or phone calls specifically and only about that.
It would have been, you know, conversations in passing where we would talk about numerous things and I would have said: how are things going? But I would have also updated him about the phone call with Michael McGuigan.
Q. And what did you tell him?
A. My recollection would be that Michael feels comfortable with where he's at, feels that the Consultants are, are right and he feels safe and, and I think that's probably as much as I would have said.
MR DE LA POER: Ms Bullock, thank you very much indeed for answering my questions.
My Lady, there are no questions from Core Participants.

Questions by LADY JUSTICE THIRLWALL

LADY JUSTICE THIRLWALL: Thank you, Mr De La Poer. Thank you, Ms Bullock.
There are just a couple of questions not about your conversations with Tony Chambers but we have been hearing in recent days about the development of managers within the NHS?
A. Yes.
LADY JUSTICE THIRLWALL: And I just would like if

I may to ask you a very few questions about your own CV.
A. Sure.
LADY JUSTICE THIRLWALL: So you started off training as a nurse in 1984 at the Royal Bolton Hospital?
A. Yes.
LADY JUSTICE THIRLWALL: I can't quite remember, was that before there was a requirement that nurses had to have a degree?
A. Yes, it was.
LADY JUSTICE THIRLWALL: So this was the --
A. Yes.
LADY JUSTICE THIRLWALL: -- old style nursing training.
A. It was old style, you were employed by the hospital and trained by the hospital where you would then subsequently work. Project 2000 --
LADY JUSTICE THIRLWALL: That is what it was.
A. -- was where it then became a degree profession and you were trained by universities.
LADY JUSTICE THIRLWALL: Yes, thank you. So as you tell us I think you worked as a nurse in various roles until December 1999. I am assuming from that that although you had management roles, you were still working clinically as a nurse as well?

A. Yes.
LADY JUSTICE THIRLWALL: And then in 1999 you became a Clinical Risk Manager. At that point were you still nursing?
A. Yes.
LADY JUSTICE THIRLWALL: You were sort of combining the two?
A. So for the whole of my 40 years, I maintained my nursing registration.
LADY JUSTICE THIRLWALL: I saw that, yes.
A. For almost the entire -- I gave up my nursing registration in September 23 --
LADY JUSTICE THIRLWALL: Yes.
A. -- knowing that I was retiring in June 24.
LADY JUSTICE THIRLWALL: And so up to 23, were you still actually going on to the wards?
A. Yes.
LADY JUSTICE THIRLWALL: And being a nurse?
A. It was, I -- I did that intentionally as it was a great opportunity to go out there and to speak to patients, to speak to staff and for me it was one of the few concrete ways of understanding what it felt like to work at my organisation or to be a patient at my organisation.
And, and I think that was usually best source of

intelligence that I got.

LADY JUSTICE THIRLWALL: And do you think was this part of your thinking that it might also encourage people who had perhaps not come from a traditional management or leadership background to think: there's someone who's come through as a nurse? Do you think -- was that part of your thinking?

A. Yes, yes, it was. And I would very much made it my business to take part in leadership development, whether that was in ward environments or whether it was, you know, in a classroom and basically the organisational development team that I had in both hospitals Mid Cheshire and UH&M felt that my story was a good story, you know, to tell people in terms of career development and that you could aspire from being a nurse to be what you wanted to be.

LADY JUSTICE THIRLWALL: Thank you. And at paragraph 10 of your statement you say that you undertook a BSc in psychology and biology. When was that?

A. That was ...

LADY JUSTICE THIRLWALL: Just roughly?

A. Roughly I would say early '90s.

LADY JUSTICE THIRLWALL: Early '90s. So you are still nursing before you go into a larger management

role?

A. Yes, yes.

LADY JUSTICE THIRLWALL: And were you paid to do that?

A. No, that was in my own time. I did it at night school.

LADY JUSTICE THIRLWALL: It was a night school thing.

Was there any support from the hospital, I mean in terms of giving you any time off, any study time?

A. No.

LADY JUSTICE THIRLWALL: Or was it all in your own time?

A. No, it was in my own time.

LADY JUSTICE THIRLWALL: Thank you. Then the other training courses, conferences and learning, internal and external, again was that sponsored in any way or was it all self-driven?

A. So the training that I referred to there would have been sponsored in that I would have been given the time to go and do that.

I think the only -- there was a management course that I did, a financial management course because that for me was one of my weaknesses, and I -- I paid for and sourced that myself. But other than that, the courses

and conferences that I did would have been I would have been given the time to do those.

LADY JUSTICE THIRLWALL: And would you have been spotting those courses and saying: I would like to go on them, or was there someone, as it were, talent spotting and saying: why don't you do this course?

A. By and large it was me spotting those courses. Also if I went into a new role -- I always made sure that throughout my career I had a mentor and if I changed job I would have a coach and sometimes those mentors and coaches would say: well, this is where you are at, have you seen this?

Also so for example when I was a Clinical Risk Manager and that was a new job, no predecessor, I met with a whole group of clinical risk managers who were all relatively new and specific courses were being run for clinical risk managers that only they would know about, no one in my organisation would particularly know about those.

So in effect through networks, that's how I would become aware of what these courses were that were available.

LADY JUSTICE THIRLWALL: And you mentioned in your statement and you have just mentioned it there that when you went into a new role, you would have a coach. Was

that the norm or was it just good fortune that wherever that happened you had a coach?

A. I -- I think it was very much personal preference. I always felt that a coach was useful. You know, in terms of you know me getting to understand, because it's when you take on a new role in particular a large complex organisation, you know, it's quite difficult and you do need to understand why are you feeling like you are feeling about certain things, what is it that's triggering that, what is it about me, myself, that's triggering that?

So coaching I have always found as something particularly useful and helping me to reflect on my day, my time, that situation that went badly or that situation that went well, that reflective piece was really important and something that you normally don't get time to do.

So that period of time with a coach was really crucial in, in giving me the head space to do that.

LADY JUSTICE THIRLWALL: Yes. I understand and I suppose first of all it requires the self-knowledge to see that you might benefit --

A. Yes.

LADY JUSTICE THIRLWALL: -- from something like that --

A. Yes.
LADY JUSTICE THIRLWALL: -- which some people may be better at than others?
A. Yes.
LADY JUSTICE THIRLWALL: But again was that something that was already in place or did you ask for it and it was given to you as a matter of course?
A. I asked for it --
LADY JUSTICE THIRLWALL: You asked for it.
A. -- and sourced that myself as well. Yes.
LADY JUSTICE THIRLWALL: Presumably it was paid for by the organisation?
A. Yes, yes. I would say all of my coaching was paid from by the organisation.
You know, some might see coaching as pink and fluffy. I would see it as pretty critical to evaluate your thinking, yes.
LADY JUSTICE THIRLWALL: Yes. Thank you very much indeed, Ms Bullock. Does anybody else want to ask any questions arising out of that or anything else? No.
Thank you very much indeed for your evidence. You are free to go.
A. Thank you.
LADY JUSTICE THIRLWALL: Mr De La Poer, I think it is convenient to take the break now.

MR DE LA POER: Yes, please.
LADY JUSTICE THIRLWALL: And we will start again at 11 o'clock.
(10.42 am)
(A short break)
(11.00 am)
LADY JUSTICE THIRLWALL: Mr De La Poer. We have got Dr ...
MR DE LA POER: Professor Smith is with us.
LADY JUSTICE THIRLWALL: I beg your pardon, Professor Smith, do remain seated while you take the oath.

PROFESSOR JUDITH SMITH (sworn)

Questions by MR DE LA POER

LADY JUSTICE THIRLWALL: Yes.
MR DE LA POER: Please could you give us your full name.
A. Judith Ann ^ Smith.
Q. And, Professor Smith, is it right that you have provided to the Inquiry two witness statements, one dated 7 June of last year, the other 3 January of this year?
A. That is correct, yes.
Q. Is the content of those statements true to the best of your knowledge and belief?

A. It is.
Q. Are you the Professor of Health Policy and Management at the Health Services Management Centre in the School of Social Policy and Society at the University of Birmingham?
A. I am.
Q. And have you held that post since 2015?
A. Yes.
Q. I am just going to briefly review how you reached that point which you deal with in a little more detail at the start of your second statement. Have you worked in health services, research, evaluation and development since 1995?
A. Yes.
Q. And prior to that, were you a senior manager in the NHS?
A. Yes.
Q. And did you reach that position having undertaken the NHS graduate management training scheme?
A. I did.
Q. And just to help us when you say "senior manager", what sort of role, description did you hold?
A. I was a general manager of effectively a division within a hospital, a period of that time it was for Women's and Children's services, that was the

last role I held in the health service.
Q. In terms of your teaching and research and its focus, is it on the organisation and management of primary and integrated care, evaluation of new models of care, healthcare management and organisational governance?
A. Yes.
Q. And are you one of the authors of the main international textbook on health management?
A. Yes.
Q. And no doubt there are very many other academic publications for practitioners, policy and academics?
A. Yes.
Q. Between 2015 and 2022, were you the director of HSMC and a member of the university's leadership forum?
A. Yes.
Q. And you have also had a period as the Director of Policy at the Nuffield Trust and been employed at the University of Birmingham as a Fellow and then senior lecturer and you have also been a researcher undertaking a fellowship at the Health Services Research Centre in New Zealand, and advised the New Zealand Ministry of Health on policy?

A. Yes.

Q. And finally, have you also undertaken the role of a Non-Executive Director between 2014 and 2022 and from 2020 to 2024 you were the Deputy Director of Health and Social Care Delivery research programme at the National Institute for Health and Care Research?

A. Yes, just to be clear that I was a Non-Executive Director of the Birmingham Women's and Children's NHS Foundation Trust and then that other role you referred to was with the National Institute for Health and Care Research, one of their funding programmes.

Q. And you were also an expert adviser on the on NHS organisation and commission to the Mid Staffordshire NHS Foundation Trust Public Inquiry and you were enacted as an assessor of the Inquiry's recommendation?

A. Yes.

Q. Your full CV, of which that is just a part, will be published.

If I turn back to your first statement, you have helpfully arranged your answers to the questions you were asked by the Inquiry into a number of topics and we are going to work through those topics as you give evidence and the first such topic is the context and nature of NHS provider management and leadership.

And here can I preface my questions by saying that as I know you know, the Inquiry has already heard from Sir Robert Francis whose report has been published, he deals with much of what you deal with here particularly in terms of the development of the NHS and of course we have also heard from Professor Dixon-Woods, an academic colleague of yours, and again you have had an opportunity to read both of their evidence and their reports, haven't you?

A. Yes, I have.

Q. So we can deal with this first section relatively briefly, not least because your report will be published, but you begin by making an observation about the NHS and in particular that it is a large scale and centrally managed healthcare system and that most -- where NHS England has responsibility for operational management of most of the service, sharing a policy direction with the Department of Health and Social Care, also very much within the public understanding.

What perhaps the public will know less about is how that contrasts with other high income countries and what the difference is and I just wonder if you could just tell us how other countries do it?

A. The NHS is considered to be one of the most centrally managed health systems in the -- in high

income part of the world.

Probably a more common approach in countries such as perhaps the Scandinavian countries or indeed in France or Germany would be that a Ministry of Health set central direction and priorities but they will be more local discretion often about the actual implementation of those within local health organisations or health districts.

Q. And has recent policy analysis by the NHS Confederation concluded that the tendency towards central oversight and performance and management is in fact increasing despite what may be said is the objective?

A. Yes, it does say that. That's work by Professor Chris Ham. I mean, there has been commentary over decades, actually, right to the recent past about the -- some of the sometimes unfortunate effects of having that centralised approach and how that can work in terms of that relationship between what people sometimes call the centre, I guess now that would be NHS England and the Department of Health and Social Care and how that can impact on the boards, the Chief Executives of NHS Trusts.

And that has been described by I know Sir Robert Francis and Professor Dixon-Woods talked about that in

their evidence but General Sir Gordon Messenger talked about that in his review and Sir Ron Kerr did in his review of NHS Executive leadership which I think was in about 2017, if my memory serves me right so it's something that's been a concern for a long period of time and critically, I would say, in -- has been cited in Inquiry reports as a sometimes unfortunate contributor to NHS culture when it's not working as it should.

I know Bill Kirkup talked about that at Morecambe Bay and Robert Francis did in relation to Mid Staffordshire.

Q. What you say is that:

"This can create cultures and incentives whereby boards and managers are more vested in narratives of success and reputation management rather than open and honest communication to the public and the centre about problems and deficiencies. As problems are hidden this can prevent system learning and improvement."

And is that a particular concern you have about the model that is operating in this country?

A. Yes, it is and I think it's one, it's one where I feel some of the other things I address perhaps later in my statement there are some things that could be done to start to address that. I mean, things have

been done before but I think, for example, moving towards professionalising and regulating NHS management could help because one consequence of that could be if it were to be associated with a new or revised Code of Conduct for NHS managers and leaders could sometimes embolden them to feel it's absolutely right to tell the truth if things aren't going as they should, if they have got problems, if they are struggling as a kind of counterbalance to what you were describing there about that pressure to make it sound like things are okay and be more concerned about reputation management.

It could perhaps alter a kind of balance of power a little.

Q. Staying -- and we will come to the Code of Conduct and the regulation in some greater detail -- with the NHS and how it's structured and ultimately how that may be relevant to the facts that this Inquiry is investigating, what you say at paragraph 11 is that public and media perceptions often assert that the NHS has too many managers. And I think you from research have a view about whether that public perception is right and whether ultimately the perception that managers are a bad thing is right as well.

So I wonder if you could just help us with that a little bit, please?

A. My view -- and I set it out in my statement -- is the NHS is in fact under-managed both in relation to other healthcare systems but also as I say in my statement with having approximately 4% of its workforce in management roles contrasts with about 10% in the wider UK economy.

So -- and again there has been work by a range of academics including Professor Ian Kirkpatrick who have studied the sometimes unfortunate consequence of that of having managers who are too stretched and have argued that there should be more NHS management capacity. Clearly it needs to be properly trained and developed.

And I do think it's unfortunate that NHS management has quite a negative public perception and it's sometimes denigrated because that doesn't help people feel as valued as professionals as they could do which again connects across to what we may discuss about what could help about professionalising NHS management.

Q. Now, one of the comments you make is about the need for a world class management system I think you are there quoting one of your academic colleagues in paragraph 11. And I suppose the challenge that I invite you to assist on is: if the system is demoralised, under-funded, feels a sense of moral injury, as you say a negative public perception, how is it that such world

class managers are to be attracted?

A. I think many of the managers and senior managers in the NHS are world class. I think there are absolutely excellent people doing very difficult jobs enabling us as a population to have some really world leading healthcare.

However, that's not always the case. But in terms of what attracting other people to NHS management, I think -- I mean, sometimes a critique has been made that NHS management can be because the NHS is so large it's almost like a it's own world and it's not always been easy for people who have come into NHS management perhaps from local government or the private sector or the voluntary sector, so I think when we consider both how NHS management could be further professionalised but thinking about its training and development I think always making sure there are opportunities for programmes that are not just about developing the people who happen to be already in or inside, but that are explicitly open to others with experience from other sectors. That has been tried at different points in the past with some success but I think trying to keep that openness and wider vision is important for a service that's as large as the NHS.

Q. Now you deal with the concept of hybrid

clinical managers and leaders and you describe this as another distinctive feature of healthcare management and leadership is that such managers are also clinically qualified and combine that with their clinical work. Does that present any challenges or opportunities the fact that there are such managers who aren't pure management?

A. I mean, in the, in the international context there is a strong tradition of clinically qualified professionals being in management roles and actually as I explained about a third of the managers in the NHS are in that position.

And that's usually considered to be a positive thing because people are bringing their very direct experience and expertise, perhaps as a doctor, as a nurse, as a physiotherapist, a pharmacist they are bringing that into the management community and that I say is considered a positive thing.

I think where it can be more challenging and again I explore this in my statement is people often move across sort of laterally, as it were, from their clinical role into management. There's often very little, if any, training and development for them in the kind of actual management skills. So that's -- I think that is a concern and it's -- sorry, the other thing

I would say is that we know from again from research that's been done by Professor David Buchanan and others that the hybrid management roles are particularly difficult to occupy because people have been in one world and then another.

I think it was mentioned yesterday in Gordon Messenger's evidence about it was like going to the dark side. But there is that sense that you have somehow crossed over. So again I think that is where having training development and support for people to take on those roles is particularly important, but no, overall it is a good thing but it's quite a complicated situation for those individuals.

Q. And is it your view that there is insufficient support and training currently for those making that transition?

A. I think it's very variable, that links back to the point that yes, the NHS is very centralised but it's also quite federated as is often described.

So I think there are, there are NHS Trusts or Integrated Care Board areas who do provide training for those sort of managers but others that may not be available to them either for reasons of resource or because it just hasn't been, hasn't been put in place. So I think there's definitely more that could be done,

again it connects to what I say in my statement about regulation and professionalisation of managers absolutely needing to be explored alongside really good training and development, so preparation for roles as people enter a management role whether as a, you know, somebody starting out on their whole career or somebody moving across laterally at middle management level or indeed moving into an Executive role, I think it's really important that training is available to people.

Q. The final matter for this first heading in your report is you concluded that section by citing Sir Gordon Messenger and Dame Linda Pollard and we have heard something of this yesterday:

"The medical profession does have a unique responsibility for leading behavioural change where necessary and supporting a positive culture within their sector where all staff flourish, whilst also they draw attention to the flawed assumption that simply acquiring seniority in a particular profession translates into leadership skills and knowledge."

Now, are those comments that you would associate yourself with and support?

A. Yes.

Q. Just explain to us, please, why there may be this flawed assumption about the fact that you are

senior in a particular profession and that that doesn't translate into leadership?

A. Some of that seniority absolutely does translate because people are leaders right from early in their -- or their career, certainly their healthcare career, a Consultant will have led a team of clinicians, a nurse will have led a team of nurses on a ward or in a department.

And they will have, yes they will have led in other ways which could have been leading around setting the culture of their team, encouraging people's career development and so forth but where they may not have the skills could be in areas like some of more complex financial management, it could be about planning and strategy, it could be about the management of quality and safety. I know a very significant concern of this Inquiry.

You won't automatically have had that sort of skills, training or indeed in some areas of human resource management, some of the skills training that people perhaps would be much more likely to get if they had been on the NHS graduate management training scheme as an entrant to management. But it's much less likely for others including those we are talking about here of a clinical background.

Q. Do the Royal Colleges have any role in promoting leadership skills in doctors?

A. They do and in fact the medical Royal Colleges were instrumental in establishing the Faculty of Medical Leadership and Management that was set up I think it was around 2011. And that exists as a body that accredits training for medical leadership, people can -- clinicians can join that faculty at different levels of sort of fellowship and it advocates for clinical management. So I think that is an example where in that case the medical Royal Colleges established something that I know is very valued and I know particularly, for example, young aspiring clinical leaders often associate themselves with that faculty or take part in its programmes.

Q. I am going to move now to your second topic which you have headed "Oversight and Regulation of NHS Management and Leadership" and you have already touched upon it.

There are going to be two parts to this: first of all just look at some of the things that you have said in your first statement and then we will conclude this section by just considering the consultation that opened at the end of last year which you deal with in greater detail in your second statement.

Is it right to begin this topic by acknowledging that in fact it's been over two decades since there was a serious and concerted recommendation that senior managers be regulated in some form or other?

A. Yes, it is. I mean, that was very much a recommendation of the Kennedy Inquiry into the events in Bristol and which led to the work on the NHS Code of Conduct for managers which I know you have had Ken Jarrold here discussing that.

So yes, it is a topic that's recurred in -- in other reports such as -- I have got a list of them here haven't I?

Q. You have The Lord Darzi?

A. Lord Darzi's earlier report, Ian Dalton, who -- in 2010, Robert Francis, Sir Stuart Rose, when he reviewed NHS leadership and more recently Gordon Messenger and Linda Pollard. So yes, it's been a recurring theme and indeed a recurring debate, I would say, in health management circles.

Q. Let's start with the Code of Conduct for NHS managers which the Inquiry has had up on screen previously and heard Mr Jarrold speak about.

If we just remind ourselves of this being a particularly important principle, put first by Mr Jarrold:

"Make the care and safety of patients my first concern and act to protect them from risk."

Now, that and the subsequent I think six principles are the foundation, the bedrock of that code.

What's your comment about that code and its -- whether it's an appropriate sort of doctor

^ I think he meant document for the regulation of managers?

A. I really like the code and it's why I set it out in my statement in the way I do and I remember back in 2001/2 being really encouraged by the fact that the move was being made to develop the Code of Conduct and I also like -- I like the fact it's concise and I like the personal nature of the statements. They feel to me very clear and looking at them now, what it's almost 25 years later, they still feel to me very real and relevant.

Q. Now, you have had a long experience with the NHS. We know that Mr Jarrold has expressed his disappointment about the fact that despite the fact it was launched by the Chief Executive of the NHS, Lord Crisp as he is now, that there wasn't really an uptake on it, it certainly didn't become embedded in NHS culture.

What's your understanding and perception about why,

you having read it and been so encouraged by it, that it just withered on the vine?

A. I think I would say two things. I think the first one I would say is that that was the time when NHS Trusts were first being able to become Foundation Trusts with a greater degree of autonomy and independence from the NHS, that was certainly the intention.

So I think -- I think that was a factor that was something about they were to be operating in that more autonomous perhaps competitive environment and perhaps there was -- may have been less oversight of an issue such as that, but I think that's certainly a factor.

I think my other one would be something I talk about here and in other places in my statement is about there is a tendency it goes back to the centralised nature of the NHS that a lot of guidance is issued but sometimes as it's issued it's not clear what it's replacing or if it's replacing something.

So things come out but then can potentially sometimes wither on the vine as I think sadly the Code of Conduct did to some extent.

So I think there's something for me about going forward, if we were to have a revised Code of Conduct for managers as part of some system of regulation, it would be really important that it was in that more

statutory form and more similar to how the General Medical Council, for example, have their Code of Conduct; that if something's changed in it, there is a consultation about it and it's clear what the changes have been and then what the new version is; does that make sense?

So there's something about the "how" there of how it's done but I do think there were contextual reasons that just led to it falling away to some extent in the early 2000s.

Q. Can I invite you to consider what may be a concern in some people's mind and whether that is your experience and perception. The reason that this isn't attractive to at least some group within the NHS or the wider Government is because the moment you are introducing a code like this which starts with patient first, that the great challenge around resources and money is made secondary when in fact that is often driving so many decisions.

So in other words that you are creating an impossible conflict because you are effectively saying to people: the resources are a secondary concern, the patient is primary. Do you have any sense that that is a concern which exists within the system, and if so, where within the system?

A. I mean, the -- the senior and other NHS managers I know and have encountered throughout my career I think practically all of them would subscribe to this and they are there because they want to make patient care to be as good as possible and to preserve and improve patient safety.

They are however also very aware of their duty to spend public money wisely and I mean that was the reason why I think it was the 1999 Health Act where it was brought in alongside the responsibility of NHS boards to have a financial -- responsibility for financial performance, a fiduciary duty, alongside it was brought in the responsibility for patient -- for care quality and patient safety.

So they -- I think health managers and health boards, they hold those two duties in tension day by day and year by year.

Where I think -- what I think is important if we are to move towards having this sort of code again would be that it would apply not only to the managers in NHS Trusts or indeed I would say in primary care or other parts of the provision part of healthcare, but my view would be -- and I am clear about that in my statement -- it should also apply to managers in for example NHS England or perhaps the Care Quality Commission, some

of those what we sometimes call arm's-length bodies or the centre because I think there needs to be a whole management community that's having that concern and I think that would help, as I have mentioned earlier -- I think I have -- to I guess embolden managers sometimes if they do feel they need to take a personal stand. And that could be an issue in a department or a ward, through a board or through a Chief Executive having a discussion with, I don't know, the regional arm of NHS England.

There's something about helping all of those colleagues in those interactions to feel that it's appropriate and safe to make those calls, as it were. But with a -- yes with that framework of a Code of Conduct.

Q. Speaking of people to whom you think it should apply, you also make clear in your statement that Non-Executive Directors and chairs --

A. Yes.

Q. -- also ought to be subject to it?

A. Absolutely. No, I think that's critical. And that's because they are part of a collective corporate board and they play a very important and responsible leadership role.

Q. Now, one aspect of the way in which there is

a degree of accountability or oversight over senior managers is the Fit and Proper Person Test which you also deal with. And Tom Kark King's Counsel looked at the first attempt at that and identified a problem with it and we will just understand what the problem was we are going to hear from him next week?

A. Yes.

Q. But could you just give us a thumbnail sketch of exactly what he thought the problem was so that we can understand why we have had the recent publication that we have?

A. I think he felt that yes, it's been implemented, for senior managers and board members in the NHS, but I think he felt it was being more consistently applied for -- I think he talked about barn door issues of unfitness to practise such as criminal convictions or bankruptcy. But perhaps less so for matters of more general competence and performance and fitness for a board level role.

So I think yes, there was that nuance that he applied.

So perhaps there's something about my take on that would that needs applying a bit more in the spirit rather than the -- what's the word -- sort of the very specific, does that make sense? I think, I think that's

what he was driving at.

Q. And we have had recently published the Leadership Competence Framework which is intended for board level recruitment and you comment that that does seem to close the gap that Mr Kark was speaking about.

Have you had an opportunity to consider that Leadership Competence Framework and do you have a view about whether it's fit for purpose, whether it is going in the right direction, we heard from Mr Jarrold, for example, he thinks there are rather a lot of words; that is my paraphrasing of what he was saying.

Do you have a view about that?

A. I think it's -- I think it's a helpful move that that thinking is going on. But as I think I say in my statement I would agree with Mr Jarrold about there are a lot of words in that document and I -- it takes me back to my point about what I like about the previous NHS Code of Conduct for managers that it's concise, it is personally focused, it's clear and it feels like to me that it can last for a good period of time.

Now that clearly does, a Code of Conduct does need to be supported by a set of behaviours or standards which again is something for example the General Medical Council have for doctors. You need that for people to understand how they are to behave and

apply that behaviour and indeed then you can train against those, those standards.

I'm not quite sure that the competent -- the recent competency framework for me quite gets there and my other concern about that based on my experience working alongside the NHS and in it would be that: what does that replace? Where does that leave the -- I think it was called the Healthcare Leadership Model from about 10 years ago, where does that now go?

But how long will this one last for? It's this issue of how new documents or guidance as I said earlier come out but it's not clear what is then retired which is the one that's then the current one and how is it actually to be applied in practice.

Q. So is the solution to that that you need one definitive document which is then the subject of an iterative process to revise so that we are always talking about the same, doctors have Good Medical Practice, for example?

A. Yes.

Q. There are multiple iterations of Good Medical Practice but everybody knows I just need to go to the latest version of Good Medical Practice?

A. Yes, and for me, as I express it in my statement, that is about a the Code of Conduct, a set of

behaviours and sort of leadership standards which I guess could be like Good Medical Practice but absolutely then supported by training and development so a requirement for Continuing Professional Development for managers which that doesn't exist at the moment. But also I would argue for some form of having -- some form of revalidation, for example, you would use those, those standards for that.

Q. But by the sound of it you are not in fact, I put it this way, looking to reinvent the wheel with what you think needs to happen. You are simply pointing to a model which you think could easily transfer across and you have mentioned the doctors' model more than once?

A. Yes, and I think actually -- I mean the work that's been done here on the leadership competencies could feed into that. But I think my, my question or my challenge is more about: how is this, could this now be something that is, yes, more formalised and clearer actually.

And to avoid a term that I know you have heard already in the Inquiry, my colleague Professor Mary Dixon-Woods talks about policy or priority thickets I think NHS management leadership development has been in a policy thicket or it certainly is sometimes. It's

hard to -- I think I -- in my statement I point to work that the King's Fund did looking at all the series of leadership and management reviews there have been, but for me that is reflective of what I am talking about here. We keep trying to reach a goal and I'm not sure we have quite nailed it.

Q. So we come to what you deal with under the heading of "Potential benefits for managers of regulation" and let's deal with two things right upfront.

Firstly, and we heard this from Dr Clamp from the PSA, that regulation can cover a number of different mechanisms, people generally immediately think about statutory regulation as per the doctors with a statutory regulator, but do we need to be careful that when we are talking about whether regulation is a good or bad thing that we don't necessarily mean the most stringent form?

A. Absolutely. I -- I agree with that.

And I know that the possible sequencing of how regulation might work is, is in the current consultation by the Department for Health and Social Care.

No, I think for me, I think it can be approached in a more gradual way and I would emphasise again my point that I think a Code of Conduct, some form of professional register, a requirement for Continuing

Professional Development and some form of revalidation with -- I mean the Fit and Proper Persons Test I think fits in there as well.

But I think that sort of bundle of group or interventions or what -- I think that could really help to sort of start to, to professionalise health management and leadership more but to give it sometimes it is a sort of a courage I think sometimes about speaking out, speaking up, about what to do or not to do and I think also to encourage some necessary sometimes to have a bit more of a degree of professional independence from the centre, as it were, because I do also talk in my statement about how it would be valuable for NHS management and leadership to have its own sort of professional body and there are different UK and international examples we could look to for how that might work.

Q. So when you say professional body, something equivalent to the GMC or something equivalent to the BMA if we were to look at the doctor model?

A. Either of those are Royal College.

Q. The Royal College?

A. Or a College. I mean, for example there is an Australasian College of Health Service Management for Australia and New Zealand, there is a Canadian College

of Health Leaders, that is the sort of thing. Or I guess there is some similarity to the Faculty of Medical Leadership and Management.

Q. So just one aspect I want to ask you about there, this idea of a register and how that might work practically. In the statutory model the register is maintained by the statutory regulator, the statutory regulator has a statutory structure for determining who gets on the register and it has a statutory structure for ensuring that people who transgress are removed from it.

So in that strictest statutory model, that's where the maintenance of that register comes from. Outside of the statutory model, how does that work in practice? How do you have a body determine who's on it and who shouldn't be on it?

A. I mean, I am not really an expert in that in the detail of how, how that would work. I mean, I know I think one of the ideas out for consultation is a voluntary register, isn't it, and I can see some attractions to that because actually once you have got a register and if it is considered a good and appropriate thing you should be on it, there would be a question to ask probably why you had chosen not to be on a voluntary register so I can see the advantage of

that.

So as I say I am not an expert about -- as Dr Clamp who you spoke with yesterday is about, about these matters.

But I think what I would say is there's something about the, having -- if you have got the register you have got the Code of Conduct, so you have got a requirement for Continuing Professional Development and you can belong to some sort of College for support and educational purposes and so on. It's about countering that denigration of managers, it's starting to feel perhaps more proud of being a health manager and leader and having more mutual professional support.

Sorry, yes, and to get back to your core question, I think to move to a, a sort of GMC type of registration for managers straight away there would be a risk of managers feeling that of itself could be rather punitive or even because I think there are concerns, I think I deal with these in my second statement, about how that might feel and be experienced so there's something about taking this, this I consider them really a professional group through a process of becoming more professional but I don't think it necessarily has to go to that absolutely formal type registration straight away.

Q. You have mentioned the consultation, that was

going to be the second part of this topic, so let's turn to that now. I am now looking at your second witness statement and the Inquiry has heard numerous times that this consultation mentioned particularly this week and of course it's there available publicly for people to respond to.

I just wonder if you could assist us please by just giving us a summary of what it is that the department is consulting on so that we can use that as a springboard to just better understand your views about the options?

A. So the Department for Health and Social Care is consulting on the type of regulation, which managers should be in scope, what type of body should exercise a regulation function, the types of standards that managers should be required to demonstrate and how the introduction of a system of regulation might be sequenced. So it's those five key areas that they are seeking views upon over a 12-week period.

Q. And we heard this from Dr Clamp the phrase "right-touch regulation". Is that a feature of the consultation; in other words the principles of proportionality centrally are extremely important to be borne in mind?

A. Absolutely and that is behind what I was trying to describe just now as well about the potential

for moving in a step-wise approach towards the regulation. Because I think also this is in the consultation document, it's very clearly my view as well. To be proportionate between the issues of accountability on the one hand but also the support and professionalisation of the managers on the other.

Q. And you deal at paragraph 12 of your second statement on page 4 with the fact that there are four possible approaches and if you just headline those for us, please?

A. Yes, the four approaches in the consultation that are suggested are a statutory barring mechanism, a professional register, full statutory regulation, and accredited voluntary register.

Q. And if you could, and you set this out at a number of points in your following paragraph, where do you land with what's appropriate and the sort of factors that ought to be borne in mind when presented with those options?

A. I mean, just to say as well, I think that whatever comes out of this consultation, it will be really important. I think it is the NHS management community and representatives of it from different levels and parts of the NHS work in partnership with Department of Health and Social Care to sort of work out

how this should be, that will be really important.
But for me as a minimum I think it will need to include a professional register and I say whether voluntary or compulsory, I am open about that, and as I have indicated earlier, I feel that even a voluntary one would probably be in effect could be considered compulsory. But then a Code of Conduct, a requirement for Continuing Professional Development and the use of the Fit and Proper Persons Test.
Q. Now, one of the comments that you make in your second witness statement about the code is you identify as we have already covered the 2002 code. You also draw attention to the Nolan Principles of public life and a third Professor Don Berwick's principles for leading a high quality and safety healthcare system and we haven't talked about those yet.
If you want to have them in front of you they appear at 47 on page 17 of your first witness statement and I wonder if it's worth, if you don't mind, just reading out what Professor Berwick suggested and what your view is about the way he's formulated it?
A. Yes, I mean, my reason for mentioning that was -- I mean, because I have talked about the Code of Conduct already, the Nolan Principles are well known and I know actually they are connected in with the

leadership competencies that NHS England have recently issued.
Professor Don Berwick is a recognised international expert on patient safety and care quality and he was brought in by the UK Government in the wake of the Francis Inquiry to help, review and advise about patient safety so that's when he -- when he issued what's actually it's a -- his document was called "A promise to learn -- a commitment to act". It's a commendably short document.
The principles he talks about in there are placing the quality of patient care, especially patient safety, above all other aims. Then engage, empower and hear patients and carers throughout the entire system and at all times. Then foster wholeheartedly the growth and development of all staff, including their ability and support to improve the processes in which they work. And, finally, embrace transparency unequivocally and everywhere in the service of accountability, trust and growth of knowledge.
I think I have, I have included those because again I think they are concise. They feel to me again they are quite enduring and they pick up a number of the themes that I know you have discussed with Sir Robert Francis and Professor Mary Dixon-Woods as well about

transparency about the patient voice and the primacy of quality and safety.
Q. Now, just one final matter on the consultation which is a comment that you make and I'm sorry to have moved you between your two statements. You say this at paragraph 13(vii) on page 5 about investment in training and development; so in other words not just what does the system look like, but how do we get people to operate well within the system?
So can you just please amplify why you have drawn attention to that particular feature and the degree to which you think it's important?
A. I have drawn attention to it because it's also highlighted by many others such as Sir Stuart Rose in his review of NHS leadership and by Sir Gordon Messenger and Dame Linda Pollard in their review a couple of years ago and I think when people undertake those sort of reviews it's a frequent finding they are quite surprised that for a service of such an extent and so many employees that the managers and leaders are not actually formally required to undertake particular training and development but also how patchy it can be, the resourcing and provision of that for them.
And actually in my first statement I reference work by the Health Foundation -- esteemed Research Foundation

in London, who did work looking at NHS management, I think it was in 2022, and again particularly highlighted the fact that people again, particularly clinicians moving into management, many of the ones they, they surveyed and worked with in that study hadn't had any training and development for the role.
So I am, I just really want to emphasise that point that I feel that professionalising and regulating management I feel the time is right for that, but I also feel the time is right to really support, resource and put in place more systematic and more available training and development for people and particularly at those key, key points of transition.
So starting in your management role often if you are in a mid-management role and I think another critical one is when you are moving to board level as an Executive, I think that's another one.
Q. Thank you. So we will go back to your first statement, please, and we have dealt with many of these topics before but under your third heading "Leadership qualities and behaviours for senior NHS managers", you begin that section by talking about the consequences of uncompassionate healthcare leadership.
I just would like you, please, to speak to the topic of uncompassionate healthcare leadership and the

degree to which you think it is a problem in the NHS in 2024?

A. Yes, that's very much drawing on work by Professor Michael West and also by Suzie Bailey and colleagues at the King's Fund in London they amongst others have done a lot of work thinking about and researching what is core compassionate healthcare leadership and I think there has been increasing focus on this almost I would say particularly since the Francis Inquiry, actually because after the Francis Inquiry the establishment of the NHS Leadership Academy was very much based on the desire and commitment to have a more compassionate form of healthcare leadership.

But to the point of the concerns about this. Again, in my statement I -- I highlight work by Michael West and the King's Fund of some of the risks of having uncompassionate leadership and a lot of those, they include things like -- well, ultimately can lead to very difficult context and experience for staff in the NHS and as a consequence of that can sometimes lead to care not being as it should be for patients. And Michael West I think helpfully in his research sort of draws that together and has studied this as well in practice, what he calls the importance of leader support so that -- which goes back to the point about training

and support for managers -- that if leaders are well supported by training, by resources, by feeling people care for them in different ways and that can be a leader, whether it is at a ward level or a department or a whole Trust, that they will make better decisions and be more effective managers and deliver overall better services.

So I think that it's a really important body of work that is that really brings together that leadership, compassion and the impact on services.

Q. Because it may be thought that those who are exhibiting uncompassionate leadership are doing the very opposite of what the two codes Professor Berwick and Mr Jarrold seem to place as the number one objective?

A. Mmm.

Q. So although it is the case that it seems to be your experience that senior managers all say yes that code is a really good idea, is it right that we still, whatever people are saying about when they think about it and are not under pressure, that's a good idea, we still see these behaviours of uncompassionate leadership even in 2024?

A. Yes, I think the -- I think the question to be asked is: why it is some managers and leaders find themselves exhibiting uncompassionate behaviour and this

body of research by Michael West and others would say that it's not always going to be a deliberate thing, it will be because of the pressures they are under or the situation they are in or the surrounding culture of their particular department and organisation.

So I think -- I think a point I am making today and throughout my statement is that these things are all connected actually. The -- the values that are in a Code of Conduct but how they are lived out by individuals, the training and support they have to be able to do that, but also having a proper framework of accountability for if that -- if that goes wrong and I guess the other bit we haven't talked about much yet but I am sure we will at some point is the kind of where the governance of the organisation brings all these things together and the role the board and its sub committees and so on play in all of this because I think that's really important as well, the kind of the -- the corporate and clinical governance of the organisation; how it -- because that's actually what will hold together and enable a compassionate leadership and management approach.

Q. That is your fifth topic. Before we get to that, we will just deal briefly and we have already touched on this in many ways already, your fourth topic

which is the training and development of NHS managers and leaders and you have already talked about how important that is and how important that is that it's properly resourced.

You identify a number of bodies in the course of your statement and I would just like you to just explain who they are, what they do and are they effective. So we begin with the NHS Leadership Academy established in 2012 and where we are with that.

A. Yes, that was established in 2012 as part of the response to the Francis Inquiry and it has delivered many different leadership programmes, including some I have to say delivered by my own university under contract to the Leadership Academy, and for example they oversee the educational training for the NHS Graduate Management Training Scheme at the moment, which is also delivered by the University of Birmingham and the University of Manchester.

And many people have been through those programmes both sort of lay managers and, and clinical managers and some of that support remains. But the NHS Leadership Academy itself has had to move through at least two sort of organisational changes about where it is located and its programmes, my understanding is, the funding for them operates on a different basis now where local

organisations have to provide more of the resource for their staff to go on them than was the case when it was established.

So it's still there and still provides learning programmes but people access management and training and development sometimes also through programmes organised or commissioned by their local Trust, there are bodies such as the King's Fund who provide those business schools and others so there's quite a diverse range of provision but with some oversight of that by the NHS Leadership Academy as well.

Q. If we just understand practically what the NHS Leadership Academy does, you have talked about it providing courses. I mean are these residential courses, are they part-time courses, how long do they take, who can access them, is there any pre-qualifying criteria for going on a course at the NHS Leadership Academy?

A. It's quite a diverse picture, actually. So -- and it might be worth following up separately about that with those colleagues. But there is a mix. Some of their courses are online and available for any managers and clinicians to do and I think to my knowledge, I haven't checked recently, they are freely, you know, available at no cost, some of those.

Then there are some of those that you can follow with some additional support and some are accredited qualification-based programmes.

So the Elizabeth Garrett Anderson programme which is delivered by the Universities of Birmingham and Manchester, that does result in an MSc in Healthcare Leadership when people have followed that. There are other programmes that I haven't got the detail to hand at the moment, but people have come to them from -- have attended those from all over the NHS and it's, you know, main -- mainly NHS Trusts but also the Care Quality Commission NHS England and other bodies as well.

So they do serve a really helpful purpose I think in bringing people together from different parts of the service for their development.

So another programme I have mentioned there that they have offered is the Nye Bevan programme and that has been one that is very much about preparing people for board level positions and I know that's been one that a lot of people have been on from the NHS across that 12 or 13 years and to my knowledge that one is still open for people to attend and that one -- sorry, to finally answer your question, that they do -- ones like the Elizabeth Garrett Anderson and the Nye Bevan programmes do have a residential element to them.

There's been some shift to slightly hybrid after the pandemic but those two were definitely mainly or they had a residential component plus distance learning.

Q. You have mentioned already and you -- of course you undertook the NHS Graduate Management Training Scheme that has been going for a long time now and presumably I infer from the title open to people who have undergraduate degrees; is that right?

A. That's correct, yes.

Q. Again what sort of length is that course and what -- in a thumbnail sketch what are people being taught on it?

A. I mean, it's existed since 1956 and it's I think almost throughout all that time it is effectively a two-year Graduate Management Training programme. It comprises a mix of practical placements, trainees are placed usually in one sort of geographical organisational setting, so they will do work-based placements in different management roles, they will also undertake an educational qualification. Currently that is the Elizabeth Garrett Anderson programme which they do at postgraduate diploma level, and they will also have what are called, there will an Action Learning Network, they will meet with other trainees regularly with a tutor to reflect on their experience and they

will have a range of other skills development and so forth. Over the years the Graduate Management Training Scheme, it's varied in how the educational provision happens. So when I was a Graduate Management Trainee we did a three-year postgraduate diploma with the Institute of Healthcare Management that existed at the time. But there has always been that mix of academic qualification, an element of skills-based development but a lot of your time actually based in an NHS Trust or a primary care organisation working as a junior manager with a mentor closely sort of supervising you.

Q. Now, staying with the topic of training but moving away from specific courses and talking about areas of training. What you say at paragraph 63 is that:

"Training will be needed to ensure that managers can read different types of complex data, understand how to report and act on concerns and support or challenge colleagues as appropriate to any discrepancy or incident."

And I just wanted you to amplify that, please, and why you have particularly identified that as being an area that managers need to be well-equipped to deal with?

A. I think that is absolutely critical to

clinical governance, that being as the name suggests the processes that are in place in a, in a health organisation to make sure that it's able to understand what's happening from a clinical and patient safety point of view and take action where that's needed, to improve things.

And over time there's been more and more data that are available and I think that is a very, very good thing that there is a lot more data about patient quality and safety. But what is critical I think for both managers and again I -- I feel of particular importance as well for NHS board members to be able to understand and read those data and reports of them.

I mean for even me as a health services researcher, it's quite complicated when I was an NHS Non-Executive Director sitting on a Quality Committee to read and understand all of the data because they are presented in many different forms and that is the clinical data and also there are all the data, for example, staff survey data, data about patient complaints about patient experience.

But my -- so my point here is I think it's really important that in whatever standards are developed or if there were to be requirements for Continuing Professional Development for managers that part of it is

around being understanding and updated on those data and how to read them and particularly for NHS board members. Yes, that is about Non-Executive Directors who are coming in often from -- well from outside needing to understand what the data are and how to read them. But actually, I don't know, if you are a finance director, you won't necessarily understand how to read some of the mortality and morbidity data and likewise, if you are a coming from a nurse or medical background you won't necessarily understand all the financial data you are seeing at the board, do you know what I mean?

So I think this whole issue of data and its governance and people being trained how to understand those is really important.

Q. Now, you have mentioned your experience as a Non-Executive Director and you identify that training for Chairs and Non-Executive Directors is not presently mandated. Is that something that you would wish to see changed?

A. Well, I think -- yes, I mean, it links to my point about regulation and professionalisation of health management than it should include Non-Executive Directors and Chairs and I also suggest in my statement that because there used to be the NHS Appointments Commission that had a role in recruiting Non-Executive

Directors and Chairs and also overseeing certainly their induction, I can't remember whether it was their other training.

But I think, I think that is important that that is mandated. I mean, it is often provided either at local level and there is a lot of training available, for example, through the organisation called NHS Providers and some people access the training from other, other bodies such as the King's Fund and other sources.

So it's there. But it's making sure that I think, yes, that everybody accesses it and that it does include some of these skills aspects like the point I have made about data.

And it could be -- it could be about NHS finance because, and particularly if you were a Non-Executive Director who's been asked to be on a finance committee or on the Quality Committee, you know, what you need may want to be tailored but I think there could be more of a framework and a requirement about that, yes.

Q. So we move to your fifth topic, the role of NHS boards and quality and safety governance and it was --

LADY JUSTICE THIRLWALL: Sorry Mr De La Poer, just before you move on to that. Just so that I have understood it correctly, there is available in various

different guises from various different places training which would assist Non-Executive Directors in all the areas that you have identified?

A. Yes.

LADY JUSTICE THIRLWALL: But it's patchy, et cetera? But if it were --

A. The take-up is patchy, I think -- well, may not be as extensive as it could be.

LADY JUSTICE THIRLWALL: But given that a lot of it is online it may be the geographical patchiness may matter less than it might otherwise have been the case.

So the question I was just simply wondering about was: is there any difficulty about saying that before someone is -- before someone takes up their position as a Non-Executive Director, they will have received appropriate training in respect of NHS finance or whatever it might be? Is there any reason why you couldn't just do that? Maybe people do that already I don't know.

A. Yes, I -- definitely because as I understand it at the moment, the arrangement -- and I say this in my statement, the arrangement is this is overseen by NHS England but organised locally. NHS Trusts will often have a induction programme for their Non-Executive Directors but clearly it's obviously one or two

individuals often joining at a time.
And that is the significant availability of that particularly through NHS providers, some of that is in person again now. Of course it all used to be and of course I personally think there is some downsides to more of it having become online and I think it's also something that could and should be picked up in appraisals of Non-Executive Directors and I think it is in some cases.
But it's this in some cases and variability point that --
LADY JUSTICE THIRLWALL: Of course by the time you are appraising people, then they have been in post for a while?
A. Exactly. I think it is reasonable to have an expectation you will do a certain core of briefing and training when you join.
LADY JUSTICE THIRLWALL: Yes, thank you, sorry, Mr De La Poer.
MR DE LA POER: Not at all, my Lady.
Topic five is the one that you said that you were expecting we would come back to, you are quite right, the role of NHS boards in quality and safety governance.
I just want to go to some parts of this but I did want to give you the opportunity because you indicated

earlier that you regard this as being absolutely central to the whole structure of how things can be improved and kept safe.
So can you just speak to that, please, for a moment or two, just why is it so important that the NHS board acts in such a way as to ensure good governance?
A. Well, I think that two points, the first is one I made earlier about the fact that an NHS board has got this dual responsibility for patients' care and safety on the one hand and financial and resource management on the other, you know, they are its two formal duties.
My other one would be is that we know from Inquiries, and particularly I would highlight here the Mid Staffordshire Inquiry that was undertaken by Sir Robert Francis, and actually Liverpool Community Health which was that Inquiry was undertaken by Dr Bill Kirkup because in both those cases, they pointed to the failure of the board and its failure to govern and assure patient safety and quality as a central point and in fact Robert Francis on the day he launched his Inquiry report in 2013, I mean he -- I quote here and it is in my statement but he said: this was primarily caused by a serious failure on the part of a provider Trust board, it did not listen sufficiently to its

patients and staff or assure the correction of deficiencies brought to the Trust's attention.
And I note that in the Care Quality Commission they have what's called the well-led framework which I am sure you have probably discussed already, forms part of the assessment of NHS Trusts when the Care Quality is reviewing them and their guidance about the well-led framework again makes it clear that the buck stops with the board of a Trust in terms of quality and safety.
Q. So one of the matters you draw attention to -- here I am looking at paragraph 84 on page 30 of your witness statement -- is the idea I think which was first mooted by Professor Sir Nick Black about a Chief Quality Officer role and I would just like you to explain what you understand that that might be, why that might be a good thing and whether there is a risk that a board is going to become too top-heavy, too complicated, there are too many board members with particular interests so just incorporating all of those aspects please tell us about a Chief Quality Officer role?
A. Professor Sir Nick Black who -- he's a renowned international expert on health research, particularly clinical audit and he is a clinician by background, he -- he was brought in to work with Professor Sir Bruce Keogh after the Francis Inquiry

looking at quality and safety in the NHS. They particularly spent time actually looking at Trusts that were considered to be particularly struggling or failing.
But it was around that time that he, he wrote and talked about this idea of the Chief Quality Officer and I think it's a role that has been used more in the United States. I just mentioned it. I am not advocating that every board should have one. But there's something about what he says here about having making sure that someone on the board has got the technical and scientific expertise about all the domains of quality about effectiveness safety patient experience and so on, and also the understanding of the -- he talks about the behavioural organisation barriers to making change.
I think what this raises for me and why I included it in my statement is it's for a board when thinking about, or I guess a chair but with the board members, thinking about the skills they have got around the board table to be sure they have got those sort of skills.
Now, maybe it might be the Medical Director has got those or the nurse director; they tend to be the colleagues who do have the kind of lead for quality at the board table. But I think his challenge is, I just

felt it was an important one to air, that that has been a debate. It hasn't been around so much recently but it was as I say about a decade ago.

And, sorry, the final point I'd make on that one is I think it causes us to question, and it would cause a board to question, even if say your medical and nurse director have got those skills, have they got the time to put to this?

So it may be, and I think in some Trusts, there is often a deputy or associate Medical Director for example who may have -- almost be in that, sort of that role, someone who's like the guardian of the data and the insights around quality and I'm sure we'll come back to it about -- well, it is my next point, isn't it -- the Quality Committee.

Q. Yes, and that's exactly so, the next point.

So tell us please why do you say that the board Quality Committee has a critical role?

A. So an NHS Trust board will usually have some effectively subcommittees. There is actually not a formal requirement to have a quality subcommittee, but to my knowledge the vast majority if not all Trusts do.

Why I think it's critical is it's where clinical governance comes together really with corporate governance. It's where -- I mean clinical governance

happens throughout the organisation where staff are looking at data about quality and safety, working out patterns, working out if actions need to be taken, if there are problems. But that all really comes together in -- the Quality Committee is where there's that board oversight of quality and safety for that duty of the board for quality and safety, just as you'd expect in the finance committee the same is happening for that, that other duty.

Q. Now you have identified in your statement the risk of such a committee becoming a talking shop or a belief that that is something that needs to be avoided.

Why is there such a risk with this particular type of committee?

A. I think there's some helpful guidance from NHS Providers about board subcommittees, which I include some of that in my statement in fact in this paragraph.

I mean, board sub committees are where, in a sense, the board does its more detailed work and does its detailed scrutiny of the work of the Executive of the Trust. There's, there's -- so it needs to be purposeful and there is certainly a school of thought that it should not be too big either. It should just be a small number of Non-Executive Directors.

There's also increasingly discussion about the fact

at least one of those Non-Executive Directors should be a clinician by background so to help them under -- because they are likely to more better understand some of the intricacies of the of the data and the issues. But it's at the Quality Committee where you will be reviewing data.

Let me try and bring it to. Life so when I was on a Quality Committee we would have some data, we would have routinely, about patient complaints, about mortality data, we reviewed deaths in the Trust, but also we had topics that we would review -- have on a rolling basis. So they could be parts of the Trust, so we may have a particular focus on, I don't know, rheumatology, for the sake of argument, or what's happening in operating theatres, but also might have a focus on something like how we are assessing and using data on patient experience or staff experience. So there will be a mix of -- does that make sense -- of topics and areas.

But it's -- my experience was it's where you get really the more in-depth insights into what's happening. You work closely with particularly the Medical Director and the nurse director but also colleagues would be brought in sometimes to present and discuss issues happening in their area and that might be because they'd

got problems or because they'd got new developments that you wanted to understand that were going to be properly clinically governed, so ...

And then the other critical part of that, there's the work of the Quality Committee, but it's absolutely how that then feeds to the board; so how much time does the board give to hearing from the Quality Committee, yes, and how are issues then -- how do you decide what to particularly raise with the board as, as concerns sometimes.

Q. Now, you have described it as needing to be small and that can be -- it depends on size. If I give you a number that we can take from our evidence that on the face of documentation from the period that we have been looking at QSPEC, which is the Quality Safety Patient Experience Committee, which is a sub-board committee at the Countess of Chester, has what appears to be 22 people on its invite list.

Is that -- I'm not saying every meeting all 22 turned up. But, is that small? Is that what you mean by small or do you mean fewer people than that?

A. No. That, that to me is large and from my experience and my reading of guidance from people like NHS Providers, I'd would normally expect as I indicated I think in my remarks just now three, possibly four

Non-Executive Directors at most, probably three, then chief Medical Officer, a chief nursing officer.

Often actually you might have the director of workforce or human resource management if you are considering workforce issues in the Quality Committee that you often do. They probably would be actually the main members of the committee. There may be one or two others in attendance. Perhaps there's a nurse or medical lead for sort of clinical governance who works to the chief Medical Officer or chief nursing officer.

But no, there were relatively, certainly in my own personal experience of being a Non-Executive Director and others that I know who have been on quality committees elsewhere, they're quite, quite small but intense meetings, if that makes sense.

And I think that's actually quite important to keep focused on the work because there's a lot of work to do in a Quality Committee and there are always a lot of papers to read, but -- and often quite a lot of follow up work to do. But I think they need to be relatively small to be effective in my experience.

MR DE LA POER: My Lady, I am about to move to the next topic which is culture. I am reasonably confident that I will finish before lunch even if we take a break now. I am just conscious we have been going for an hour

and nearly 25 minutes since the last break and I wonder if this would be a convenient moment?

LADY JUSTICE THIRLWALL: Yes, thank you.

Just before we break, I just wonder if I might ask a question in relation to the evidence you have just been giving about the Quality Committee.

You have heard from Mr De La Poer about the size of the committee in the Countess of Chester and I think it was chaired by a single Non-Executive Director. I don't believe there were any other NEDs on it.

But just from your perspective and your experience, what difference did the committee make? What change was achieved or what developments were made? Just could you give us a couple of examples and --

A. When I was a Non-Executive director?

LADY JUSTICE THIRLWALL: When you were a Non-Exec, sorry, on the Quality Committee.

A. Yes.

LADY JUSTICE THIRLWALL: You know, was it worth the time and effort? Let me put it that way.

A. Oh, absolutely.

LADY JUSTICE THIRLWALL: So what sort of thing did it improve?

A. One I remember quite strongly is we had a number of Never Events in the Trust related to our

operating theatres and the Quality Committee played a key role in exploring that, in oversight of that and we had additional meetings in fact at the time and external expertise was commissioned to help us both understand the problems and then afterwards to put in place a programme of development work to help resolve some of the issues that had led to those Never Events.

So that's one I remember particularly. That's perhaps -- what's the word -- that's a particularly significant one in my mind because it was about those safety failings.

LADY JUSTICE THIRLWALL: Can I just ask you then, just in relation to that one, had there been no Quality Committee it sounds to me like that's something that would have had to be dealt with anyway within whatever structure there was or do you think it wouldn't have been?

A. Well, it would have been dealt with, but I think that when you have got something of that nature it's really important that it's connected into the work of the board --

LADY JUSTICE THIRLWALL: Yes.

A. -- because of that responsibility for quality and safety. And I think, I mean ultimately one would have to ask the Executives and the clinicians in the

Trust how they found that experience, but it seemed to me at the time that they welcomed the fact that some of the -- I think there were three of us Non-Executives who were on the Quality Committee -- that we and the committee were taking a strong interest, were asking questions. But, you know, I remember going to meet with some of the staff in the theatres to discuss the concerns.

But I think it's that mix of a good Non-Executive Director needs to provide support and challenge and I think a good Quality Committee needs to provide good and robust support and challenge.

LADY JUSTICE THIRLWALL: Can you give a sort of more routine example --

A. Yes.

LADY JUSTICE THIRLWALL: -- of change?

It doesn't matter if you can't, but if you think of it later you can always send us a letter.

A. I think -- oh, I know another one. This is relevant I think to the work of the Inquiry. It was a more recent one towards the end of my time as a Non-Executive Director.

The -- Donna Ockenden had published certainly her interim report into the events at Shrewsbury and Telford Hospitals and, as a result of that, there were a whole

set of what people called Ockenden actions; things that needed to be addressed around maternity safety and so forth. Well, our Quality Committee had a real focus on that. I mean, we were Women's and Children's Trusts with large maternity and neonatal units within that.

So the Quality Committee was the place that did a lot of the really sort of more in-depth and detailed oversight of what was happening then about -- because there were requirements around multi-disciplinary training of midwives and obstetricians and oversight of fetal monitoring -- I am trying to remember the others -- about staffing levels and so forth.

So we were across all of that, but we reported that into the board and I mean in that case there was a connection across. I was the board Non-Executive maternity safety champion and the Medical Director was the Executive one. So we took that work from Quality Committee to the board. But along with -- I wasn't the chair of Quality Committee at that point, but he worked really closely with us on that.

So in one sense that was more routine in that it was a requirement for us to do it, but it was really helping us to lift the lid on our maternity services and understand better where some of the pressures were and what we could do and needed to do to support, to invest

to challenge and so forth.

LADY JUSTICE THIRLWALL: And things came to the Quality Committee via what route?

A. I mean the Medical Director was the key Executive together actually with the nurse, with the nurse director. They were the two who developed the agenda for it.

But feeding into it, there were other committees such as there was a sort of what I would call a more, there was a clinical Quality Committee for the Trust bringing together people from all different parts of the Trust, there was then a non-clinical Quality Committee so that was, I don't know, considering matters to do with estates and engineering and medical equipment, all sorts of things like that. There was -- I think there was a health and safety one as well.

So those ones fed in but it was the nurse director and the Medical Director, together with their sort of governance secretariat, who worked with the chair of the Quality Committee to determine its agenda and bring matters in. And we did always have on the agenda of the Quality Committee, there was, as I recall it, there was always space for particularly the nurse director actually to talk about what she used to refer to sometimes as the stones in her shoes, which were things

she was sort of just a bit worried about and wanted to have more of a look at, whether clinical or from an HR sort of perspective.

LADY JUSTICE THIRLWALL: Thank you. Is 10 minutes long enough?

MR DE LA POER: Well, I have reflected upon that request and I am just conscious to achieve efficiency and if we took a break then and then broke at 1 pm and had another hour, it may be better if we broke for an early lunch now so we incorporate that break effectively within lunch and then start again at 1.30 pm, which will still give us plenty of time for this afternoon for the work we need to do. But I am in my Lady's hands whether we use a bit more of the morning or break now.

LADY JUSTICE THIRLWALL: Professor Smith, would it be very inconvenient for you if we took the lunch break now?

A. Not at all.

LADY JUSTICE THIRLWALL: Would that be all right?

A. I am in your hands.

LADY JUSTICE THIRLWALL: Thank you. In that case, we will rise now and we will start again at 1.30 pm.

(12.30 pm)

(The luncheon adjournment)

(1.30 pm)

LADY JUSTICE THIRLWALL: Yes.

MR DE LA POER: Professor Smith, your sixth topic is culture and there are just two relatively modest areas to ask you about in relation to this. The first is Professor Dixon-Woods who gave evidence at the start of the Inquiry, you have had a chance to consider her evidence.

Is that evidence with which you agree, do you disagree with any part of it? Where do you stand on what she's told the Inquiry already?

A. I agree with Professor Dixon-Woods's evidence and would particularly draw attention to her strong focus on the importance within clinical governance of problem sensing, not comfort seeking, I find that a particularly helpful concept and approach.

I think the one area where in her evidence where I have a slightly different view from her is about some of her comments about human resources and human resource management.

I see that as when that is working effectively I think I don't think that necessarily has to be a problem around issues of dealing with incidents or concerns if you have got a really well-functioning board and Executive team or indeed well-functioning teams at division or service level.

So I would have perhaps put slightly less emphasis on that but I respect her views and thoughts about it.

Q. It may be that the point she was making is that that is commonly dysfunctional whereas I think the point you are making is the when it is functional, it is not a bad thing?

A. Yes.

Q. So the other modest area of questioning in relation to culture, if I can take you to page 41 at paragraph 117, I just invite you to consider what you say at the start of paragraph 117 which as I say is at the bottom of page 41.

We have looked already at the idea that those at board level, even though they are the top of their organisation that their behaviours can be influenced by looking up; in other words to those who they perceive as being in charge or responsible in some way and that that can lead to those damaging behaviours such as promotion of reputation and so on.

You make a slightly different point here because here you are commenting upon the culture of those who are at the top or in the centre depending on how you are conceptualising the arrangement, namely DHSC and NHS England and what you say is that:

"They appear too often unable to be self-critical

or demonstrate sustained learning in respect of its behaviour towards those NHS leaders looking to it for guidance, support and direction."

And I just wonder if you could just please explain to us what you mean by that and to give us an example perhaps of what you are referring to in terms of a lack of reflection or poor behaviour?

A. I think what I'm talking about there is, and it's the point I draw out there in the example from the Messenger and Pollard review, is that whilst policy guidance will talk about yes, support, and the positive ways in which things would happen that's not always the lived experience of Chief Executives and Chairs and other senior managers sometimes in their interactions with the centre.

And I am drawing there on, as I said earlier, on reports and work that's been done on that both in Inquiries but in other contexts, such as the work we mentioned earlier for NHS Confederation or Sir Ron Kerr in his report about Executive leadership. So there's something about the stated behaviours and approaches not always perhaps being lived out in practice and my sense would be and from reading those reports and what we have heard about it from other Inquiries is that sometimes that those individuals themselves are in difficult

positions in for example NHS England because they are subject to political central pressures sometimes that may be -- may be affecting those behaviours that can sometimes be problematic for those on the receiving end of them.

So, for example, I guess to do with the pressure to deliver targets, that's one that's well known and well researched. Gwyn Bevan and Chris Hood, two professors who wrote about that talked about targets and terror and I think that work, although some time ago, remains relevant in that context.

Q. The supplementary point you make in relation to this issue and perceived problem is that unless change happens at that central level I think it's your view that it's hard to see how the local culture can change?

A. Yes, and it's -- this is a concern that's been raised over -- over the years and it's behind or for me in some of my suggestions in my conclusions in the statement about what might be able to help resolve some of that or shift that culture, you know, include my point about that the -- any move towards regulation of managers should include the senior managers within, for example, NHS England and also that it feels appropriate to me that the duty of candour should apply to

individual managers and Non-Executives and Chief Executives but again to those individuals, so that for example in NHS England or the Care Quality Commission that those managers and leaders are being treated as part of that same management community and may in its own way assist them because I think they have their own dilemmas that they are having to handle sometimes in terms of behaviours and priorities.

Q. Your penultimate topic, topic seven, is entitled "Openness, speaking up and transparency" and as you will appreciate the Inquiry has heard a great deal of evidence about this.

I just want to take you to paragraph 124 which you will find on page 44, where you refer to the guardian service and the suggestion that perhaps speaking up has to some degree had its day and that we need to progress from that to a constructive two-way dialogue and we also see in your paragraph 128, the emphasis being on listening as well.

And I just wanted to draw upon your experience and expertise, please, just to comment upon that and whether you think that it's time for that evolution?

A. I don't in any way think that speaking up has had its day and I am very supportive of the whole approach of Freedom to Speak Up and of the role of

guardians.
I know -- I know you have heard evidence on that particularly from Sir Robert Francis and I think that continues to be a work in progress and I think it is progressing.
And even in my own time as a Non-Executive Director I saw that taking shape and starting to have an effect so I think that is important.
It's -- cultural change is difficult but I think having the guardians as people who staff can go to, obviously they need to know that, but as a route for speaking up it's really important. But the reason why I talked about this needs to have now as well focus on the listening and responding, is partly because that's what evaluation and study of the Freedom to Speak Up Guardians is telling us because I think it is one thing to speak up but to start to understand how -- what it looks like where there's a good response, a positive response, and I think this is where evaluation and research can help, what does it look like in a Trust where they are able to -- consistently, one hopes -- respond to episodes of speaking up and why is it they can do that and perhaps other places it doesn't happen?
And I think then to understand try and understand what is it that can help managers and leaders listen,

hear, make those responses and some of this may well connect across to what we have talked about earlier about regulation and indeed training for people as well because it's quite difficult work to do.
So I think that that's why I was thinking about it's more it is part of, this is now a few years in, I think people are giving attention to that other important part of that, that process.
Q. Your final topic is headed "Reasons why Inquiry recommendations don't work" and you deal in your first statement with that topic but you are able to bring it up to date in a way and draw together the various themes in your second statement and I wonder if I can just invite you to turn that up so you have that to hand, it starts on page 7, paragraph 20.
Here you refer to the House of Lords Statutory Inquiries Committee publishing its report in the early autumn of last year and the observation made in the report is too often Inquiries are failing to meet their aims because Inquiry recommendations are not subsequently implemented, despite being accepted by the Government.
And obviously that report goes into a great deal of detail and people can read it for themselves; it is publicly available. We have you here, however, to get

your insights into it. I mean, first and foremost, do you agree with the analysis and conclusions of that report? Do you think they have got it right when they say there is a problem, and this is why there's a problem?
A. I do. And I also think the report is helpful in that it's -- it's had a look at -- well, it's looked both across Inquiries in this country and looked at some international experience but I think it's really helpful that it starts to set out some possible solutions or things to try that, and I do say in my statement some of the ones I think are particularly I think have some potential, so no, I think it's a very useful report.
Q. You draw out at paragraph 24 the suggestion that a Joint Select Committee is used to monitor the recommendations of the Inquiries. Is that the suggestions they make one that you promote and say you think is a good solution to the problem?
A. Yes, I think I say in my statement that I think that would be a Joint Select Committee of the Houses of Commons and Lords that would have a responsibility for, yes, monitoring and following up routinely on the recommendations or certainly those recommendations that have been accepted by Government to follow up how well they are implemented or not.

I also suggest alongside that that it was one point in this report that -- I mean, I hadn't known about this until I read this report, but it talks about an approach used in Australia of an independent implementation monitor, a person who is appointed at the point at which an Inquiry report is published, a person of significant standing who will in one sense I guess almost have an individual role certainly for a number of months in sort of tracking what's happening about recommendations and whether on the ground or things are really happening as they are being told in policy terms.
So I just thought that was an interesting one to -- that might be considered alongside it. But it was based on what I had read in the House of Lords report.
Q. The end of the process is monitoring what recommendations that have been made. The start of that process is the making of the recommendations. I think you make some observations at your paragraph 29 drawing out from your first report and I think entirely consistent with what the House of Lords was saying in this regard; that it's extremely important that the recommendations which are developed are ones which can be and are capable of being implemented.
And so I wonder if you could just identify one or two that you think are most important when it comes to

how a recommendation should be formulated?
A. Yes, and I was very much in my thinking here, a colleague of mine at the University of Birmingham, Professor Martin Powell, has done work looking at -- looking back at Inquiry recommendations and trying to understand why they are implemented or not and he has this term "implementable". But I think it's an important term.
So I then here, as you have just said, I have drawn from my first statement when I was preparing this one much more recently just to, yes, suggest a few recommendations that are implicit in my statement that feel like they might be implementable, so I will suggest just a few of them here.
I mean one, to pick up on the point we were talking about just before lunch is to mandate the fact that there should be a Quality Committee in every Trust and to say something about the sort of membership it should have and ideas about the sort of Terms of Reference and remit. That feels to me like one -- it feels to me it's inappropriate that there isn't a mandate to have a Quality and Safety Committee in an NHS Trust, so that's one I have got.
Also to establish a Code of Conduct for NHS managers with underpinning set of standards embedded in

employment contracts and with some system of formal regulation of managers.
And also that another one that that Code of Conduct standards and regulation, as I have said before, should apply to managers within NHS England and other arm's-length bodies as well as Trusts and Integrated Care Boards.
And another one, and perhaps while I think I have talked about it already and understand that I feel quite strongly about this is that any approach to regulation and professionalisation for me must include a real focus on training and development and the proper provision of that but also expectation of that, so that those for me are two sides of the same coin.
And I guess my -- the final two perhaps that are there on the list, one was about: could the NHS Appointments Commission be re-established? I think it -- it worked well to oversee recruitment, training and development appraisal of Non-Executive Directors and Chairs.
And finally, to link together what we are just talking about, that there be some sort of formal process for monitoring the implementation of Inquiry recommendations that are accepted by Government.
MR DE LA POER: Professor Smith, thank you very

much indeed. I am conscious I have been highly selective in asking you questions in relation to well over 50 pages of careful and detailed report from you.
I just want to check with you before I turn over to Mr Baker, who has some questions for you, whether I have omitted any matter which you have not spoken about that you consider it's important that the Inquiry hears directly from you as you sit there?
A. No, I think my overriding points are about the critical importance of clinical governance about how that intersects and is part of what the board, the Chair and Chief Executive do and it is -- that it is time to professionalise and regulate NHS management, that that will happen within the complex and sometimes problematic wider culture of the NHS and that there are things that can be done to ensure that Inquiry recommendations that more of them are implemented. Many are, but a lot more could be. So I think that, yes.
MR DE LA POER: Thank you very much indeed, Professor Smith.
My Lady those are the questions that I have. Mr Baker has permission for some questions.
LADY JUSTICE THIRLWALL: Very good. Mr Baker.
Questions by MR BAKER
MR BAKER: Good afternoon, Professor, I ask

questions on behalf of two of the Family groups.
You will have seen from the summary that I have permission to ask questions over a very broad range of topics and 10 minutes to ask them. Rather than doing that I am going to focus in on one aspect and that's in relation to uncompassionate healthcare, so if we could look, please, to paragraph 40 of your witness statement. In particular the table that's under it and the table comes from the King's Fund Library Service and describes in a nutshell issues with uncompassionate healthcare and the first paragraph talks about and leads to a focus on chasing targets and a culture of fear and blame.
I think that picks up on something you said towards the end of your evidence as well about targets and fear of targets?
A. Mm-hm.
Q. How does a focus on chasing targets lead to uncompassionate healthcare, do you think?
A. I think the -- for me, a prime example of that was the -- what happened at Mid Staffordshire NHS Foundation Trust and one of the, the main factors there that Robert Francis identified and described in-depth in his Inquiry report was that that NHS Trust was so focused on wanting to become an NHS Foundation Trust which at the time was a new status with a set of

freedoms and it was regarded as something almost to become part of the -- what is the word? The first class or the more elite group of Trusts.

And he through that his report described how that led to an undue focus in that case on chasing there were a set of requirements for becoming a Foundation Trust, including some financial requirements and that that led to an over-focus on that and then a failing to -- well, again to hear, to act on and attend to significant care failings. So I think that is a good example of where the target was being chased and indeed was met and they became a Foundation Trust but leading to whilst there was significant uncompassionate care going on. So therefore uncompassionate leadership.

Q. Also there is talk within some of the evidence about a culture of self-promotion?

A. Yes.

Q. And in a sense we can see in that example the target is promotion and is reputational gain or enhancement, and overfocus upon that leads to issues such as patient safety falling behind?

A. It certainly can do and again Robert Francis talked about that and Bill Kirkup talked about that in one of his reports, I think actually it's the Liverpool Community Health one actually where he -- again

particularly that was another Trust, I think, that was seeking Foundation Trust status, but there were appalling failures of care going on in the Trust at the same time.

Yes, sorry, what was your point again?

Q. So I mean if we go back to the box under paragraph 40 of your witness statement --

A. Yes, yes.

Q. -- there is a reference within that King's Fund quote --

A. Yes.

Q. -- to:

"The shift from person and people to diseases and bed capacity can lead to the dehumanisation of patients and disengagement of leaders and staff."

So in that section there are we seeing expressed the idea that this focus on targets leads in a sense to dehumanisation of patients sometimes in particular in the sense that those patients might become a barrier or aspects of those patients' conduct, behaviour, their bed-blocking, whatever it may be, become a barrier to achieving those targets?

A. Yes, I think it's -- it's definitely the -- there is a question about what the targets are, of course.

Q. Of course, yes.

A. So there is a question that, yes, if there is undue focus on a small number of targets it can take away important management time and attention from other things that really, that really matter and in the case we are talking about here about patient care.

I would link that as well to what I have talked about today about the need for the Code of Conduct for managers and leaders, you know, when we talked about making patient care and safety one's first concern, that's why I think that is so important to have that, the point here about the King's Fund and this work talk about the shift from person and people to diseases and bed capacity, I think what that is expressing is that yes, if the -- if the target is particularly about -- yes, about bed capacity and as you were saying trying to enable more rapid discharge of patients from hospital I think it's implying that you can get into almost having unnecessary distance between you and the actual care and the services.

So you -- it might be just thinking about diseases and bed capacity but I think also there is an important point here that we are thinking about this today in terms of in this instance in terms of managers and targets but there's a lot of health and indeed

sociological research that's been done over the years that that can sometimes happen between clinicians and patients who, I don't know, might talk about "the gall bladder in bed 3" rather than the person's name or that elderly person who's incredibly vulnerable and has a whole set of needs, and the -- you know, it is known in healthcare that those distances can be put in place when people are under pressure to almost inoculate them from some of the harsh kind of difficult realities of what patients are facing.

So I just mention that because I think it's in that context of pressures that sometimes unfortunate distraction or dereliction of a kind of real focus on care can happen.

Q. But the reality is that being a hospital manager, it's a necessary part of your job to achieve certain targets and meet certain standards --

A. (Nods)

Q. -- in order to do your job?

A. Yes.

Q. And one of the benefits of regulation, if I put it that way, is it brings back into focus especially if the first goal of that regulation is to put patient safety above all else?

A. Yes.

Q. If it has a consequence attached to it, the consequence to you as a manager, as an individual career-wise, then that is, that is a good motivator, isn't it, to ensure that the natural instincts towards focusing on targets and focusing on other things don't allow patient safety to be lost?

A. Well, I think I go back to what I said this morning about I actually think having a Code of Conduct and a form of regulation or indeed professionalisation of health management, I think they can work in the positive way to help managers to hold that line if they feel that a target, I don't know, to reduce -- it could be about reducing waiting times and it might be they feel that by having to achieve that target, they are not able to put enough attention and resource into what is happening in their Accident and Emergency Department with kind of -- with that group of patients, they may then feel a bit more emboldened to speak up about to that to say, "Actually, we are choosing to -- it is going to take us a bit longer to achieve the waiting times target because it is because we are achieving achieving what for us is a really important target about quality of care in Accident and Emergency", does that make sense?

Q. Indeed.

A. I think it can help them as well.

Q. So regulation has two components to it?

A. Yes.

Q. One is to punish wrongdoers?

A. Yes.

Q. But another one provides a protection --

A. Yes.

Q. -- to managers because managers are able to say when put under pressure: I cannot do that because it is professionally irresponsible of me to do that.

A. Yes.

Q. And point to a Code of Conduct?

A. Yes, and I think that can apply at all different levels of management as well.

Q. Yes, and so being able to say to a senior colleague "I would be professionally embarrassed and potentially face consequences if I behaved in the way that you are asking me to behave", provides them with a level of protection because otherwise without that regulation and protection they -- they aren't able to meet that pressure in the same way, are they?

A. And I think also again I talk about in my statement about the potential of some harmonising of the sort of management leadership standards, for example across those that the General Medical Council has and

any new arrangement for health managers because then in that sense, when those dilemmas are faced within an organisation, the clinicians and the managers are operating within almost like the same -- that same code.

Q. Yes.

A. And which has both its challenges and protections.

Q. And the benefit to that being an external regulator, rather than being as part of a Code of Conduct that's written into your employment contract, is two-fold: first of all, it is your employer generally who is putting pressure on you to behave in a way potentially, and so recourse to your own employment contract and how your employer may enforce that against you isn't necessarily a protection. And secondly, the employment contract is a contract that exists between the employer and the employee. It provides no route of redress to individuals outside of that contract to seek professional regulation in response to something that has been done.

So an affected family member, for example, wouldn't be able to enforce duties that are owed pursuant to a contract of employment?

A. No, but if there were to be -- it would depend what the regulatory body decided upon, if there is an

approach to regulating managers, you know, it could be a Health Standards Council as Tom Kark has suggested or it could be with the Care Quality Commission. But yes, it would be somewhere else to go.

Q. Yes. And finally just to make this point I am going back to uncompassionate healthcare. The impact of that is very real when it comes to patient safety, isn't it, because if we are looking at consequences and the need to regulate in order to address a particular consequence, one might regard the impact of uncompassionate healthcare upon patient safety as being a very serious thing, something that would need to be addressed in any way possible?

A. I think we are talking here about this work is about uncompassionate healthcare leadership.

Q. Yes.

A. I think that is the --

Q. Yes?

A. -- important point.

And yes, I mean, I think the work of Michael West and others does show that there can, there can be negative impact on patients and indeed on staff actually of that.

Q. Yes.

A. And those, those two go together just as

actually elsewhere in my statements which I haven't particularly talked about today. There is research evidence in the UK and overseas that says that the way that boards do their work, boards of organisations that they need to have a compassionate, positive and effective approach because actually, you know, there has been research that suggests if their practices are not as compassionate and as appropriate as they should be it can have an impact on patient services. So it can happen in different ways through governance and through the actual leadership and management practice.

MR BAKER: Thank you. Thank you, my Lady, those are all my questions.

Questions by LADY JUSTICE THIRLWALL

LADY JUSTICE THIRLWALL: Thank you very much, Mr Baker.

Just a couple more from me, if I may, Professor Smith.

In your list of implementable recommendations which we went through, we skipped over but it is in your statement obviously, is your suggestion that you establish or we establish a central source of funding for training and development.

And you have looked, you have described to us very well, if I may say so, the sort of highly variable

access that there is for managers.

Obviously that's going to be something which will require money coming from somewhere else or fresh money coming in --

A. (Nods)

LADY JUSTICE THIRLWALL: -- to the NHS.

What sort of amount of money are you thinking about or have you not got as far as thinking about that other than to say: this should be a protected pot for training?

A. I -- I don't have the expertise to quote the exact funding because I am not, I am -- I don't.

What I am suggesting is as you know that there should be some approach to professionalising and regulating managers and that there should be both a requirement for ongoing Continuing Professional Development and more protected resource for training and development as part of that.

I mean, I think that would -- partly some of that resource is there already because some of the training is happening but it would need -- it would need additional resource but I think almost back to where my evidence started about having an undermanaged health service and that healthcare management is too often denigrated, which I don't think is helpful to it, if we

are going to do something and kind if the Government and the health system is going to do something about that, it requires a set of measures and it requires some investment.

Now, that would not be popular given the views that the public hold of health services management but I think the work of Public Inquiries, for example, in the health arena has too often shown the consequences if we don't invest in and support and properly value healthcare management and leadership.

LADY JUSTICE THIRLWALL: Can I just --

A. I am not excusing when it gets it wrong, but it just matters so much.

LADY JUSTICE THIRLWALL: No and I don't think you are saying all managers are good managers because we know they are not and that is part of the reason for the reputation that you have described?

A. (Nods).

LADY JUSTICE THIRLWALL: But the Graduate Training Scheme, from what I can tell from the evidence that you have given and from the evidence we heard earlier in the week is considered to be a good scheme and would I be right to assume that it does produce good managers and some good leaders?

A. I have got -- I think it is regarded as

a high-performing Graduate Management Scheme and I think that sometimes it has that -- for example I think in the past has won awards amongst the kind of community of graduate management training schemes in our wider economy and society.

LADY JUSTICE THIRLWALL: I am not suggesting it is the only route, but I just wanted to establish whether it is a route.

A. No, it is -- it is, it is regarded as a positive route and I think it's actually regarded often as a privileged route because the people who follow that scheme do get a lot of investment in, in terms of it's partly about the training, they get the placements, they get the opportunities to meet with others and they get access to quite senior policy and management colleagues as part of that, so it gives them a real almost like rocket boost, I guess.

LADY JUSTICE THIRLWALL: It gives them a sense of the value of what it is they are being trained for, doesn't it?

A. Yes, and they are proud of it and I think people who have been on the Management Training Scheme and I have to confess even myself at times will say: oh well, I was a national trainee.

LADY JUSTICE THIRLWALL: A bit like fast stream

civil servants, that is something that people talk about?

A. That is a very, very good parallel. It is very, very much like that.

LADY JUSTICE THIRLWALL: But in terms of the output, is it correct that we end up from as a result of that scheme with good managers and leaders, the ones who go through that scheme?

A. I think we do but we also do get good ones.

LADY JUSTICE THIRLWALL: No, I understand. I first of all want to see whether in fact this scheme which does have a high reputation does produce good managers?

A. Yes.

LADY JUSTICE THIRLWALL: And I don't want to be diverted from "but so and so doesn't". Because I think what's important, or may be important from the outside perspective, is to establish something which is as good as that and has the same outcomes as that without people necessarily having entered as a graduate because the numbers are quite small, aren't they, they are in the hundreds --

A. They are.

LADY JUSTICE THIRLWALL: -- each year and we have a need for thousands of managers, presumably --

A. Yes.

LADY JUSTICE THIRLWALL: -- at high level?

So really my question comes to this: whatever training there is to be provided for as part of this professionalising of managers, it must at least have regard to what is already there.

A. Yes.

LADY JUSTICE THIRLWALL: And what works well.

A. And if I may, my Lady, just add one point to that.

The NHS Graduate Management Training Scheme has been highly regarded over the years. But there's always been a debate and a concern about the fact you have the two years of very intensive input and support but what happens afterwards has never really been systematically developed, what happens to you afterwards.

And I know certainly, I think it is when Sir Stuart Rose did his review of NHS management leadership, he did call for an expansion of the Graduate Management Training Scheme but he also commented on the fact that we don't sort of do career planning with people or talent management, as it is called sometimes, to sort of track them through and offer them other opportunities, training, secondments, in a way that I think some other organisations do.

LADY JUSTICE THIRLWALL: Yes.

A. So you have a lot and then there is not so much afterwards, if that makes sense.

LADY JUSTICE THIRLWALL: Yes, or if you look at it from your privilege perspective you have a lot and then you should be given even more. So it is quite an interesting way of looking at it.

A. Yes.

LADY JUSTICE THIRLWALL: One can see the logical bit and, Sir Gordon Messenger gave evidence yesterday talking about the need for talent spotting and planning all the way through careers.

A. Yes, I agree with that.

LADY JUSTICE THIRLWALL: I have that point, thank you.

One other question, if I may. Your suggestion that it should be mandated that every Trust should have a Quality Committee. And again speaking as an outsider there's a dazzling array of committees within each Trust as far as one can tell and it takes a lot of time and I wonder if there's to be a Quality Committee for the reasons that you have explained, would it be unreasonable to assume that one could get rid of something else? I am not asking you to name it now but --

A. No, I think for me it's more there aren't

actually many board sub committees, for a board and how it does its work this is very much about the governance role of the Trust board. I think it has to have -- they have usually got an audit committee and an appointments committee, appointments one probably doesn't meet that often, a finance committee, and then you would usually expect quality. So it is not many, actually, for that central governance.

I mean, if they haven't got a quality committee I would sort of question where that board governance of quality, safety is actually happening.

LADY JUSTICE THIRLWALL: Okay, so this would be for those that are not doing it, this will be an additional requirement and it may be that I am thinking of the -- all the various committees that are, sit below board level --

A. Yes.

LADY JUSTICE THIRLWALL: -- which seem to absorb a huge amount of time.

A. Yes, yes.

LADY JUSTICE THIRLWALL: Before they get anywhere if they do get somewhere.

One last question about committees more generally. You mentioned in your statement I think -- well, I know you did, that we have 4% of the workforce of the NHS are

managers and then I think quite a high percentage of managers are also clinicians, I think you call them hybrid and when you say "hybrid" I am assuming those are clinicians who are still carrying out a clinical role and a management role, not those like a Medical Director who has moved over entirely into management, or is it both?

A. I think the answer is it can be both.

LADY JUSTICE THIRLWALL: So can I just ask you then, of the 4%, are these hybrid managers in addition to the 4% or are they --

A. I would have --

LADY JUSTICE THIRLWALL: -- part of it because I think that may be quite important?

A. I think of the 4%, I think the 4% is people who have management as almost all or all of their role.

LADY JUSTICE THIRLWALL: Yes.

A. And I think then in my statement I think it said that about a third of them are clinically qualified. But then there are of course many, many others in the health service who are, for example, people like, I don't know, a ward manager or the chief pharmacist and people who are very clearly sort of clinical and managerial, I think from memory those are in addition as well, but I could check that.

anecdotally from senior managers I know who are clinicians by background, so Medical Directors, nurse directors and so on, actually I think nurse directors one would usually find are full time as in their management role.

But there are some Trusts where the Medical Director may be part-time still practising as a clinician and certainly as you move down the organisation, clinical directors will probably have more of their time as a clinician and less as a manager.

LADY JUSTICE THIRLWALL: Yes.

A. But people -- I think they do -- they will talk about the pressures they face to do what can feel -- because they are also operating in two worlds almost as well: the clinical world and the managerial world but the time one is often a key pressure they will talk about.

LADY JUSTICE THIRLWALL: So by "key pressure" you mean they are working in addition to their --

A. Yes, and you know you hear some of them will make decisions about either trying to negotiate have more time for management or some stand down and go back to being full-time clinicians.

LADY JUSTICE THIRLWALL: Yes. Thank you. Anybody want to ask anything arising out of any of that?

LADY JUSTICE THIRLWALL: If you wouldn't mind, that would be extremely welcome.

A. Yes, I will.

LADY JUSTICE THIRLWALL: The question I was then going to ask you that the evidence that I have heard is of, for example, a clinician having 25% protected time for management, however it is described, that is what it is, and 75% of the time for clinical duties but in fact all of their paid time is spent on clinical duties and the management is done in what people like to describe as their "own time"; in other words, unpaid?

A. (Nods)

LADY JUSTICE THIRLWALL: And that suggests to me that a lot of management is being done at the expense of individuals --

A. Yes.

LADY JUSTICE THIRLWALL: -- rather than the NHS more generally. Is that a fair observation?

A. I -- I think that is a fair observation and certainly I have -- I mean, just here rather than from -- well, actually, it's worth, the work I referred to in my first statement by Huw Davies and Alison Powell looking at the experience of clinical managers is worth looking back at that again which, I mean, I could do for you, if helpful, about that. But also sort of

MR DE LA POER: No thank you, my Lady.

LADY JUSTICE THIRLWALL: Professor Smith, thank you very much indeed for coming. If you wouldn't mind following up those couple of points, we will check out with you that you have understood them correctly once we have had a look at the transcript.

A. Yes.

LADY JUSTICE THIRLWALL: And you are now free to go.

A. Thank you.

LADY JUSTICE THIRLWALL: Thank you very much indeed.

Now, I think Ms Brown is going to read some evidence into the record. Thank you very much, Mr De La Poer.

Evidence read by MS BROWN

MS BROWN: Yes, my Lady, I will now read two summaries that refer to questionnaires and surveys that were sent out by the Inquiry.

LADY JUSTICE THIRLWALL: Thank you.

MS BROWN: In November 2023, the Inquiry sent a questionnaire to the medical and non-medical leaders of 120 NHS Trusts with neonatal units in England. An analysis of the responses to the questionnaires have been undertaken by the Nuffield Trust and a report

produced, this report will be uploaded to the Inquiry website in due course. The questionnaire asked each Trust to describe the management and governance structure and the arrangements for reporting concerns within their neonatal services.

Questions were asked about working relationships between health professionals and managers, the culture of the neonatal unit and the involvement of parents or guardians in neonatal care.

Questions were also asked about processes for investigating complaints relating to neonatal care, the number of complaints received, and the Trust's engagement with external scrutiny in the form of professional bodies such as the Child Death Overview Panel and Medical Examiners.

Trusts were also asked to provide details of the number of unexplained deaths or unexpected patient safety incidents reported within their neonatal services over the period of one year from October 2022 to October 2023.

Details of neonatal staffing levels were requested along with copies of current policies on safeguarding, investigating neonatal deaths, Freedom to Speak Up, Whistleblowing and Complaints. Information was also sought from the Trusts on how these policies operate in

practice.

The Inquiry also asked about CCTV, the storage and administration of medication and bereavement counselling. The views of both medical and non-medical leaders were also sought on whether and how senior managers should be regulated.

Finally, Trusts were asked to reflect on whether features of the management and governance structure or of the hospital culture might inhibit the raising of concerns about the care of babies or lead to managers failing to act upon concerns raised.

What follows is a brief summary of some of the key themes that emerged. These are set out in greater detail in the Nuffield Report.

Most Trusts reported real and persistent difficulties with meeting staffing requirements with 99 Trusts reporting nursing vacancies in neonatal units.

In relation to culture, negative aspects that were cited by three or more Trusts included poor leadership and working relationships between staff groups, bullying, harassment and discrimination and NHS pressures including staff shortages, sickness, industrial action, and low morale.

However, many Trusts refer to their current initiatives to develop a positive safety culture. This

included work on equality, diversity and inclusion, promoting civility and respect embedding a just culture and strengthening collaborative working.

In discussing working relationships, Trusts referred to a multi-disciplinary team working and forum for raising and discussing issues. Many Trusts reported that they were taking part in the NHSE perinatal leadership programme as set out in the three-year delivery plan for maternity and neonatal services.

Some Trusts referred to challenges with working relationships which included differences in opinion, the existence of hierarchies and others commented upon the impact of staffing and service pressures citing industrial action in 2024 as an additional pressure.

There was broad consistency in how respondents described their processes for reporting and investigating concerns and complaints. Staff and families were encouraged to raise their concerns or complaints in the unit, Patient Advice and Liaison Services, PALS, were widely cited as available to families and the Freedom to Speak Up Guardians as available to staff in order to assist with raising complaints. Multiple teams were described as being responsible for investigating concerns or complaints depending on the particular issue raised.

Most respondents, 108, reported having at least one concern or complaint in the previous year that had been raised and investigated. The most frequently described actions taken in response to the raising of concern or complaint were communications about the issue to staff for learning purposes and making changes to clinical practice or processes.

Respondents described a range of factors inhibiting staff from raising concerns. These included a lack of reporting culture, low staffing levels and resourcing issues that left little time to raise and investigate concerns or complaints, complex and bureaucratic reporting routes and ongoing public scrutiny of maternity and neonatal care amplifying reporting requirements were also cited as factors inhibiting the raising of concerns.

Enabling factors included continuous encouragement to report, training programmes and psychology services for people speaking up. Visible Freedom to Speak Up Guardians, visible leadership and the promotion of mechanisms to listen were also seen as factors that facilitated making complaints.

For families, inhibiting factors to raising complaints were considered to include a lack of awareness about how to raise a concern, complex

reporting routes and language barriers. Enabling factors were the existence of multiple possible routes to raising a concern, widespread public information on raising concerns or complaints and encouragement from staff.

The survey respondents cited multiple routes for reviewing evidence after a death. Medical Examiner reviews were considered to be a process able to identify themes or patterns.

In general, working relationships with Medical Examiners and Coroners were viewed as positive. Many respondents also reported attendance at Child Death Overview Panels.

Some Trusts referred to the importance of data and ensuring it is visible at board level. Respondents also cited the importance of processes and cultures which enable people to raise concerns.

The importance of integrated working between neonatal and maternity services was also mentioned in response to the questionnaires. Some Trusts suggested streamlining the various processes for investigating and supporting deaths, whilst others noted that culture, leadership and support should be the main focus rather than changing structures or processes.

More generally, Trusts described a number of recent

actions they had undertaken, some were in response to the Letby case. This included reviewing and adapting policies and processes for raising concerns, incidents and deaths, enhancing governance and oversight, improving culture and raising awareness of routes for raising concerns.

Also cited as recent actions were providing support to staff, parents and families and improving family involvement in processes. Reference was also made to additional investment, changes in staffing, improving how data is used and reported with increasing visibility at board level and implementing recommendations from previous Trust and NHS reviews.

In relation to CCTV, most respondents, 99 of 120 Trusts, reported the presence of CCTV covering entrances and exits and external corridors. Some had CCTV in communal areas such as waiting areas with a minority, 8, having CCTV in storage areas for medication. No Trust reported the presence of CCTV on wards. However, some Trusts did provide facilities for video calling or access to live webcams or portals for families to access prerecorded videos.

Amongst reasons cited by Trusts for not installing CCTV within wards were privacy concerns in relation to filming areas where breastfeeding, nappy-changing,

expressing and skin-to-skin contact was encouraged.

Other respondents considered CCTV unnecessary due to the presence of staff and parents throughout the day and night. It was also noted that it was not a British Association for Perinatal Medicine requirement.

In relation to regulation of senior managers, respondents expressed a range of views. Some expressed a clear position either in support of regulation or against it. Some expressed a more qualified position and others were neutral or undecided on the topic.

From the responses that were supportive, some refer to the fact that the senior managers should be regulated in the same way as other professional groups including doctors and nurses. The contrary view expressed in another response was that managers are already subject to trust policies including on performance and conduct and further regulation was not necessary.

Reference was also made in response to the fact that there were already in existence a Fit and Proper Person Test. One response noted that any regulation would require support, education and training programmes as well as a funded regulator.

Trusts were also asked by the Inquiry to provide and comment on internal policies within their

organisations, including safeguarding policies. The Nuffield Report notes that: about half of the respondents, 61 Trusts, reported that they had reviewed their policies during 2023. For most of those 39 Trusts, their reviews of policies were triggered by the Letby case but another 10 Trusts reported reviews being triggered by changes in national guidance on safeguarding and/or the introduction of the new National Patient Safety Incident Response Framework.

25 Trusts stated they had changed at least one policy with the Nuffield Report commenting: for most Trusts, policy changes included clarifications around escalation in safeguarding processes, new checklists and flowcharts when investigating neonatal deaths, updated language and signposting in line with the national Freedom to Speak Up policy. Among the Trusts that had not reviewed or made changes to their policies, many respondents suggested that they were awaiting the outcome and recommendation of the Inquiry.

The Ian Harvey field analysis of the questionnaire responses noted that the policies which were submitted were lengthy, spanning numerous sections and issues. Some Trusts had made changes with regard to safeguarding; for example, adding a important regarding escalation of concerns and the role of the Local

Authority Designated Officer, the LADO.

Some Trusts also made positive changes in relation to Freedom to Speak Up and whistleblowing; for example, strengthening the safeguarding section to make it clear that any type of abuse or harm should go via a safeguarding pathway.

Turning to the overview of current Trust policies in the NHS, a total of 71 Trusts specifically dealt with the issue of safeguarding concerns in relation to a member of staff within their safeguarding policies. The Inquiry received a wide variety of policies in response to the questionnaires. Some differences between Trusts were notable; for example, a small number of Trusts had different policies for safeguarding children and safeguarding babies.

The level of detail included in the safeguarding policy varied between Trusts. The vast majority mentioned the role of the Local Authority Designated Officer, the LADO, and the requirement for allegations meeting certain criteria to be referred to the LADO within one working day, 24 hours.

The criteria typically that a staff member who works with children was alleged to have: (a) behaved in a way that had harmed or child or may have harmed a child; possibly committed a criminal offence against

or related to a child; or behaved towards a child or children in a way that indicates the staff member is unsuitable to work with children or may pose a risk of harm towards children.

Not all policies imposed a 24-hour limit on referrals to the LADO and some policies simply suggested that the case may need to be referred to the LADO, which imports a degree of internal judgment into whether to take the matter externally and does not comply with the 2023 statutory guidance.

Examples of good policies included those that set out the following: (a) the principle which underpins the management of an allegation of child abuse against a staff member is found in the Children Act 1989; namely, the welfare of the child is the paramount consideration. If a report is received or attention is drawn to the fact that a member of staff has behaved in a way that has harmed a child, or may have harmed a child, possibly committed a criminal offence against or related to a child, or behaved towards a child or children in a way that indicates they pose a risk of harm to a child, a line manager should be informed immediately.

(c) it is not for the recipient of information to make a judgment regarding its validity.

(d) a description of the role of a LADO is contained in the policy.

And (e) a flowchart setting out the procedure to be followed when an allegation against a member of staff is made which addresses the interplay between the safeguarding and disciplinary and human resources issues when responding to an allegation.

Another example of a good policy emphasised that the first priority must be child protection in response to the child and outlined possible actions, including: (a) a police investigation; (b) children's social care involvement; and (c) internal consideration by the Trust of disciplinary action.

This policy also set out a clear chain of command and reporting, whereby an allegation is immediately reported to the line manager who has the duty to inform a named allegations officer in the Trust. The allegations officer must then inform the Named Nurse for Safeguarding and the LADO within one working day and liaise with the LADO regarding advice.

The Nuffield Report noted that whilst some policies set out what to do when safeguarding concerns arise, other policies set out the role of the LADO but do not indicate how, why or when such a referral be made.

Some Trusts have joint safeguarding policies for

vulnerable adults and children. These are lengthy documents referring to two distinct statutory frameworks: the Mental Capacity Act 2005 and the Children Act 1989 and 2004.

Several Trusts made reference in joint policies to the steps to be taken should a staff member be suspected of abusing a vulnerable adult patient, but did not suggest the same issues might arise in relation to a child.

Policies safeguarding children covered a wide range of issues; for example, being aware of risks of child radicalisation or county lines, issues that were unlikely to be relevant on a neonatal ward.

However, only a small minority of Trusts had separate policies for safeguarding children and safeguarding babies. Frequently there were joint policies relating to safeguarding for maternity and babies.

A number of Trusts had a separate policy about managing allegations of abuse against staff, either in addition to or as an alternative to inclusion in their safeguarding policy.

Fifteen Trusts responded and provided their policies about managing allegations of abuse against staff. A further 31 Trusts did not provide these

policies to the Inquiry but referenced them in other documents. It was common, for example, for there to be a shorter section of two to three paragraphs in a safeguarding policy about allegations of abuse against staff and for the reader to be directed to a separate policy for further detail.

A total of 46 Trusts therefore were confirmed to have a specific policy in place for managing allegations of abuse against members of Trust staff or volunteers.

The separate policies which were provided ^ were typically detailed documents. They tended to include similar content, but in a more detailed form to the matters set out above as examples of good practice and safeguarding policies.

Some examples of matters commonly addressed included: (a) explanations of relevant individuals and their roles, the designated safeguard lead, the LADO, the employee's line manager; ^ (b) multi-agency strands of investigation; (c) ^ supporting those involved including the victim and their family as well as the staff member accused; (d) referral to the DBS (Disclosure and Barring Service) and/or any professional bodies or regulatory bodies; (e) engaging in thinking about lessons learnt following the conclusion of the case; and (f) consideration of suspension ^ of the staff

member.

Some policies included a concrete list of steps to be taken beyond informing relevant people, such as managers, the LADO, and the police if necessary. These steps included: ensuring the patient or victim is safe; identifying risks and developing a protection plan; completing a Datix form within 24 hours; obtaining statements from witnesses; consulting with the police if they are involved; keeping accurate records of actions taken and the rationale for decision-making; and considering the duty of candour and whether to inform the patient's family.

The use of separate and relatively succinct policies for safeguarding issues in relation to a member of staff in some Trusts contrasted with other Trusts who had lengthy safeguarding policies covering a wide variety of topics. The Nuffield Report notes that for example one policy was 56 pages long and covered topics from dog bites through to female genital mutilation.

There were a wide variety of other policies provided which specifically reference safeguarding concerns being raised in relation to Trust staff. These typically included complaints or concerns policies, professional standards or conduct policies, disciplinary policies and Freedom to Speak Up or whistleblowing

policies.

Most Freedom to Speak Up policies were short documents adapted from the standard policy and procedures following the recommendations of the Francis Report. It was common for other policies to refer readers to the Freedom to Speak Up Framework as a means of raising concerns about a staff member.

Some policies clearly delineate between a concern or complaint or a disciplinary issue and a safeguarding issue in respect of a child, recognising safeguarding as a separate issue to be dealt with through a separate procedure.

It is noted from the Nuffield Report that at least one Trust has already made this change to its policies following the Letby case.

Some examples of good practice include:

(a) a safeguarding supervision policy which notes that although confidentiality is fundamental to the supervisor/supervisee relationship it may be necessary to breach confidentiality to protect a child or young person from abuse;

(b) a disciplinary policy which included an appendix process for managing safeguarding or criminal investigations and highlights the need to:

(1) convene a strategy meeting to consider whether

investigation under disciplinary processes is necessary or appropriate;

(2) the need to inform safeguarding leads and potentially the police and LADO and;

(3) the need to consider referral to regulatory bodies or the Disclosure and Barring Service.

Disciplinary and complaints concerns policies which drew a clear distinction between safeguarding and internal disciplinary procedures and make use of flowcharts to outline the steps to be taken following an allegation including the possibility of simultaneous internal and external action being taken were also considered good practice.

A number of Trusts included very helpful and specific guidance that if a complaint, concern or allegation involves a possible criminal offence or a safeguarding issue, the procedure to be followed is the safeguarding procedure and/or referral to the police rather than the internal complaints or disciplinary procedures.

My Lady, I will now turn to the summary of the Neonatal Staff Survey.

LADY JUSTICE THIRLWALL: Thank you.

MS BROWN: As referenced, my Lady, in your opening statement, a short survey was sent out to all midwives,

doctors, nurses and managers in hospitals with neonatal units.

The Inquiry appointed Picker, a health and care research charity, to administer this survey which aimed to collect views on the culture within neonatal units across England.

An analysis of this survey is set out in a report to the Inquiry dated May 2024 and will be uploaded to the Inquiry website.

The questionnaire aimed to generate insight into the culture and working relationships within neonatal units. Respondents were asked questions relating to the overall culture and working relationships at their Trust. Across all Trusts, 32,121 staff were invited to take part in the survey. Nearly 7,500 staff working in or within NHS neonatal units in England provided responses, resulting in an overall response rate of 24% considered to be a response rate large enough to yield meaningful results.

The estimated highest response rate by occupational group, 47% was from managers, followed by nurses at 30%, with the lowest response rate being from senior managers. Over a quarter, 25.9% of respondents, stated that they had been with their Trust for more than 15 years.

Overall the majority of staff working in neonatal units had positive views of the culture in their units. Whilst 77.6% of staff believed that the culture of the neonatal unit was good, only 20.6% reported that improvement was not necessary. This was reflected in comments such as: I think there is always room for improvement in culture but I do think our unit has a flat hierarchy and a good open culture.

Over three quarters of staff, 76.5%, agreed that the culture encouraged open and frank discussions when something goes wrong at the neonatal unit. Comments such as: we have an open culture to speak up and support processes to enable this support this finding.

In terms of staff cross-working relationships the results indicated that senior managers viewed their working relationships with all other occupational groups far more positively than other groups did. Only half of all nurses, 49.7%, felt that working relationships between nurses and senior managers are good versus 87.5% of senior managers who believe this.

Likewise doctors and senior managers viewed their working relationships differently, with only 56.7% of doctors but 82% of senior managers reporting a good relationship. Two thirds of Consultants, 66.3%, felt that working relationships between Consultants and

senior managers are good, compared to a far higher proportion, 82.1%, of senior managers who felt the same.

Comments provided support for the findings for example: senior managers need to be more supportive of those working on the shop floor and: senior managers do not appear to act on concerns raised to them.

Differences in perception were also demonstrated by the fact that 82.5% of managers perceived their working relationship with nurses as good compared to only 64.9% of nurses describing the relationship as good.

Doctors were also less positive about cross-working between doctors and managers than managers were, 65.4% of doctors and 87.4% of managers viewed these relationships as good.

Regarding relationships between staff groups overall, the Picker Report states as follows:

"Where differences were observed between staff groups, nursing and midwifery were notably less likely than colleagues in medical, doctors and Consultants, and managerial roles to report a good culture and a culture that encouraged open conversations. A majority of staff in all roles felt that improvement in the culture of their unit was necessary although this can be interpreted either as a symptom of unresolved problems or more positively as an indication of a healthy

commitment to continuous improvement."

The questionnaire sent out by the Inquiry was specific to hospitals with neonatal units and focused on current culture and working relationships in the NHS neonatal units. It was distinct from wider NHS staff surveys routinely sent to all staff such as those surveys which were conducted across all staff at the Countess of Chester during the period of 2015 and 2016.

The NHS Neonatal Staff Survey 2015 and the National Staff Survey 2017 for the Countess of Chester, which sought the views of all members of staff at the Countess of Chester covering the period 2015 to 2016, will also be uploaded to the Inquiry website.

LADY JUSTICE THIRLWALL: Thank you very much indeed, Ms Brown. We will take a break now so that we can then start the evidence of the next witness and conclude without a break so we will start again at 5 to 3.

(2.41 pm)

(A short break)

(2.55 pm)

LADY JUSTICE THIRLWALL: Ms Langdale.

MS LANGDALE: My Lady, may I call the next witness.

MR JEREMY HUNT MP (sworn)
Questions by MS LANGDALE
LADY JUSTICE THIRLWALL: Thank you, do sit down.
MS LANGDALE: Can you give us your name and occupation please?
A. Jeremy Hunt and I am a back bench MP.
Q. Mr Hunt, you have helpfully provided the Inquiry with a statement dated 20 August 2024. Can you confirm the statement is true and accurate as far as you are concerned?
A. It is, although I am no longer Shadow Chancellor.
Q. Can you give us briefly a career history, please, and particularly tell us the period for which you were Secretary of State for Health?
A. I was elected to Parliament in 2005 and I was an opposition spokesman for Culture, Media and Sport until 2010 then I became Culture Secretary, Health Secretary in 2012, Foreign Secretary in 2018 and then in 2022 Chancellor.
Q. You tell us in paragraph 10 of your statement your responsibility as Secretary of State for Health and subsequently Secretary of State for Health and Social Care.
Can you set that out for us now, please: what's the

ultimate responsibility?
A. Well, I think the Health Secretary has ultimate responsibility and accountability for the NHS and what happens in the NHS -- and I think it's probably appropriate that I should open my comments by saying to the Families associated with this terrible tragedy that it happened on my watch as Health Secretary and that although you don't bear direct personal responsibility for everything that happens in every ward in the NHS, you do have ultimate responsibility for the NHS and insofar as lessons were not learned from previous Inquiries that could have been or the right systems were not in place that could have prevented this appalling tragedy, then I do bear ultimate responsibility and I want to put on record my apology to the Families for anything that didn't happen that could potentially have prevented such an appalling crime.
Q. We will be coming to the detail later, Mr Hunt, but in fact, one Recommendation that had been made in relation to Medical Examiners may well have been of great assistance in preventing a number of deaths in the Countess of Chester. We will come to the detail of that, but do you see looking back the significance of that Recommendation and how that may have made a difference in the case such as the one this Inquiry is

examining?
A. I think so. I think of all the things that could have potentially meant that what happened at the Countess of Chester was spotted earlier and the dots were joined up would have been having Medical Examiners.
I was looking at the evidence line that I think the Inquiry produced as to what happened with Medical Examiners and I think it was first mooted by the Home Office in, from memory, 2004 after the -- a recommendation from the Shipman Inquiry and then it was formally recommended by Robert Francis in the Francis Inquiry which he published in 2013 and that was accepted by the Government in 2014 and then it was piloted between 2016 and 2018.
I think that it is something that I look at as being one of the things that we took too long to implement. In fact, I remember that when I became Chancellor, which was rather unexpected, in 2022 it came across my desk again in 2023 as something that required additional funding which the NHS were not willing to fund and I made it happen as Chancellor but I think that it's unlikely it would have happened even now if you hadn't had a former Health Secretary who became Chancellor who was aware of the significance.
I will just say one thing in defence of the NHS's

reluctance to implement Medical Examiners because after we met earlier I was trying to reflect on why it was that there was this institutional reluctance.
There was a shortage of doctors in the NHS, I think historically we have never trained enough doctors and I came to that conclusion about halfway through my time as Health Secretary, and I increased the training places by 25% in 2016, and then they were doubled again when I was Chancellor as part of the long-term workforce plan.
When you have a shortage of doctors, the NHS is naturally very keen to use the doctor time that you have to treat patients that are showing up in A&Es or for elective surgery, so it takes quite a lot of willpower to take that doctor time and say: no, we need to do it to examine deaths to see what can be learned from deaths. I think it's very important you do that but I suspect that was what lay behind the institutional reluctance on that recommendation.
Q. Does that suggest a need to increase the number of doctors, the training for doctors?
A. Yes. But that has happened. You know the issue -- I mean we in 2023, the Government doubled the number of doctors that we are training as part of the NHS long Term Workforce Plan. The trouble is that takes

seven years, so my first stab at this in 2016 increased medical training places by 25%, that is a big increase, one of the biggest ever, but the first new doctors as a result of that decision didn't arrive until last year.

So that's the issue, that time delay.

Q. Where we have a look, since we have gone to it straight away, INQ0108775, that is the Inquiry legal team document that we gave you earlier, Mr Hunt, that sets out Dr Fletcher's evidence, the National Medical Examiner.

If we see there as you rightly said a moment ago, recommended back in 2003 arising from Dr Shipman's convictions and the ensuing Inquiry, 2004, you see there is a Home Office position paper, 2008, a pilot scheme. As you say, 2013 Sir Robert Francis had made the observation that Independent Medical Examiners are independent of the organisation where patient deaths are being scrutinised. Sufficient numbers need to be appointed and resourced.

What's the importance of them being independent, Sir Robert was highlighting that making the recommendation but would you add your weight of support to that that they should be independent?

A. Very much so. I mean, I think the first of all I think it's important to say that this is a problem

that is not unique to the NHS. There is a problem in health systems all over the world that unlike any other industry, there is a high number of deaths, it's completely normal for people to die in the NHS and the typical district hospital will probably have a dozen deaths a month and so in that context the risk is that deaths become normalised and you don't have a process that you would have in any other industry, the airline industry, the nuclear industry, if there was a death in any of those industries, the rail industry, you know, a huge amount of effort goes into examining why it happened and what lessons can be learned.

It's equally important, if not more important, in a healthcare setting to do the same. But because about half of us die in hospital anyway and death is a relatively -- it sounds awful to say this way but it is just a relatively normal thing in healthcare settings, we don't make the effort we should to understand.

Now, the reason that the independence matters, to go directly to your question, is because it's very difficult if you are a doctor or a nurse responsible for a patient and that patient dies, it's very traumatic for you personally and sometimes it's very difficult for you and your colleagues to accept that you may have made

a mistake and in fact all the psychological pressure on yourself is to try and persuade yourself that it was inevitable, nothing could have been done differently in the treatment of that patient.

And so that's -- I was coming at it from that perspective when I was Health Secretary, not the perspective of people who are deliberately murdering patients which is obviously very rare but tragically does happen. But I think, so I wanted Medical Examiners to happen because I wanted the NHS to have a better learning culture and better processes in place to learn from medical error, which -- I mean, a charity I founded called Patient Safety Watch estimates at about 13,500 preventable deaths every year across the NHS.

So that was my perspective but I recognise that there is a big read-across to deliberate harm done by the Shipmans, the Letbys, whoever.

Q. If we look, please, at INQ0108369, page 20, this is part of a table that the Inquiry legal team has drawn together, Mr Hunt, that demonstrates recommendations that have been made by a number of Inquiries over the years and what has and has not been implemented.

And the item number I would like us to look at is number 39 and it's Dr Bill Kirkup's recommendations

following the Morecambe Bay investigation. So it's very difficult to read there, I think, Mr Hunt, you have had a hard copy of this in any event but Dr Kirkup reported:

"There is no mechanism to scrutinise perinatal deaths or maternal deaths independently, to identify patient safety concerns and to provide early warning of adverse trends. This shortcoming has been clearly identified in relation to adult deaths by Dame Janet Smith in her review of the Shipman deaths but is in our view no less applicable to maternal and perinatal deaths and should have raised concerns in the University Hospitals of Morecambe Bay NHS Foundation Trust before they eventually became evident.

"Legislative preparations have already been made to implement a system based on Medical Examiners as effectively used in other countries and pilot schemes have apparently proved effective. We cannot understand why this has not already been implemented in full and recommend that steps are taken to do so without delay."

"Action: the Department of Health."

That Inquiry or review was something obviously you had commissioned, hadn't you?

So the message came back from that one as well that it was a really important matter in identifying for children too.

When you received that, was there anything specific in relation to this or that recommendation that you undertook, and we can go back if we want to INQ0108775, which is the general chronology of how in effect it is 21 years later from Dame Janet Smith's recommendation that finally there is a statutory footing for it in 2024?

A. I think as I mentioned earlier it was a priority for me to implement Medical Examiners, there was a cost associated to it and there was a question as to who would do it and where you would find the doctors to do it and what they would be diverted from in order to do it.

So I think the first formal time that the Government accepted that there would be Medical Examiners was January 2014 when we responded to the Francis Report which came out in February 2014 -- 2013. So I think 2014 was the first time the Government made a commitment to do this.

We implemented -- we agreed to implement and I think successfully implemented all bar nine of the Francis Review recommendations, but that one was more difficult because of the costs and also the question as to where doctors were going to come from. However, and I am not trying to defend the time it took to implement

it but it was got up and running in a number of hospitals very successfully.

Q. Yes.

A. I remember going and seeing the system at Southampton Hospital and thinking this is an absolute excellent system which is why, when I became Chancellor, I pushed it through finally and said we have got to find the money and do this, it's taken far too long.

Q. Indeed it seems to be the case that 2019/2020 there was a roll-out of a non-statutory system, wasn't there, and you say that's seemed to be effective?

A. Well, the one I saw in Southampton was when I was Health Secretary which was before that. But I think -- I am sure we are going to go on to talk about the broader issue of the delay --

Q. Yes.

A. -- in implementing recommendations from reports. But I think Medical Examiner system when it works well is incredibly important to a healthcare system because I think you -- it is not just important for learning from mistakes but it's also very important for families who have been bereaved to have someone independent that they can talk to and raise concerns with separate to the doctor responsible for the care of their loved one. And one of the most striking things

about the Medical Examiners I spoke to was, you know, they might be dealing with a number of deaths and wondering which ones they should really look at in more detail. Actually it was feedback from relatives that was a very important clue for them as to where things might be going wrong.

Q. Relatives have a key part to play in the Medical Examiner system, don't they, in terms of informing the people investigating or examining the death what concerns or suspicions or worries things they might have thought were odd, they can contribute that.

And we know in this case particularly the Mother of Baby E could have said a lot in that context. So as you say, it is a more holistic system, isn't it, getting feedback from parents as well?

A. (Nods)

Q. That can come down now. Can we have instead please INQ0101077, page 41 and this is a paragraph from Sir Robert Francis's expert report to the Inquiry and coming on to the wider point, Mr Hunt, about how recommendations can be implemented and processes that can be considered.

While we are getting that document, can you help us with -- there were many recommendations from Sir Robert's report, 290, and we understand that you two

worked subsequently to discuss those in some ways.

Can you tell us how you worked to consider the recommendations that had been made and what was to be done with them, what was your pattern of progress with them?

A. Well, my main priority in the six years that I was Health Secretary was to reduce the amount of avoidable deaths, so I was thinking about patient safety as a very, very big focus of my work. So I was very keen to implement all Sir Robert's recommendations, I think we -- as I say in the end we implemented all but nine of them.

But the thing that -- and I think by the way that he would say that it was a very good partnership between him. I mean, the Inquiry was obviously wholly independent, it was a Public Inquiry, we had nothing to do with the recommendations. But following the Inquiry there was a lot of collaboration with Sir Robert and my approach was basically we wanted to implement the spirit of everything he wanted to do, but there were things that he couldn't have known when he was making his recommendations that meant that we ended up not implementing some but also doing a lot of other things that he didn't recommend.

So, for example, he recommended as one of his --

I think Recommendation 9, completely understandably that all the regulators responsible for quality and safety in the NHS should be merged because there was such complexity in the system and we thought about that very carefully but we concluded that the regulator that identifies whether there's a problem needs to be totally independent from the organisation responsible for putting it right because under the previous administration both of those roles had been performed by the CQC and the problem was that if the CQC identified a problem and then they were responsible for putting it right, they had an incentive to say that progress had been made and people didn't necessarily trust what they said.

So we decided, I think Sir Robert agreed with this, that actually you need to keep the CQC totally independent and not responsible for putting things right where there are problems because its job is to be the kind of nation's whistleblower and so that required a lot of engagement with Sir Robert. You know, his report didn't recommend having a Chief Inspector of Hospitals, it didn't recommend having a kind of OFSTED rating of hospitals: outstanding, good, requires improvement, inadequate. None of that was in his report but we concluded that was the best way to implement the

spirit of his report.

Q. Was that a voluntary good working relationship subsequently from Sir Robert's perspective that you both discussed it? I am interested in how those recommendations were discussed between you and the footing for that, if you like?

A. Yes, I mean every time we decided -- I mean, we got his recommendations in February and gave an initial response I think the same day given by David Cameron as Prime Minister, but then the following January I gave the full Government response, having gone through all 290 recommendations and every time I didn't accept one, which was only on nine occasions, I carefully with him went through why.

Q. So there was transparency between you about what was going on?

A. Yes, and is explained what we were going to do instead to respect the spirit of what he was recommending, I mean one of them was for example he said -- this is an interesting one and I don't know if we actually made the right answer or not on it, but he recommended that there should be a legal duty on hospitals, doctors, nurses to tell the truth to patients who have been harmed.

After a lot of discussion, and we talked to all the

professional bodies, we decided to make that a duty of candour on organisations on the management of hospitals but for when it comes to individual doctors and nurses we changed their Code of Practice as put in place by the GMC and the NMC but we didn't make it a criminal offence not to because we were worried about the unintended consequences.

So we had a different way to try and achieve the same objective.

Q. Can we look at what is on the screen now, please, and, Sir Robert reminds us that his first recommendation had been annual review of implementation suggesting:

"There should be an annual review by all organisations within healthcare including the Department of Health of their progress towards implementation with follow-up review by the House of Commons Select Committee."

He says later:

"However perhaps inevitably such reviews effectively petered out although the report has continued to be referenced in most discussions on improving the NHS and protecting patients from harm."

What do you think about that mechanism, an annual review and it obviously did peter out, so in terms of

achieving we are particularly interested in corporate memory in the NHS and your successors knowing what you have been doing and continuing that where that's appropriate to do so?

A. I think it's a perfectly sensible recommendation, I can totally understand why he recommended an annual review. I think that when it came to his report that was published in February 2013, we had more than an annual review, you know, we really powered into making sure that all his recommendations were accepted. But partly because I found that that review was a very important way of forcing change in the NHS because I realised that this is a huge organisation, one and a half million people, and, you know, very busy and very experienced clinicians, they are not particularly willing perhaps for obvious reasons to take instructions from a politician, particularly one who doesn't have a clinical background.

But if a recommendation is made as part of, you know, as a consequence of a Public Inquiry it carries a lot of weight.

So because I realised this was a very good way of getting change in the NHS, I then commissioned other Inquiries such as the Morecambe Bay Inquiry, the second Francis Inquiry, the Freedom to Speak Up Inquiry and

other Inquiries.

Now, I think looking back the result is that we just had thousands of recommendations from thousands of Inquiries and no system to monitor which recommendations were implemented and which weren't and that I think is a hugely important gap to fill which I very much hope this Inquiry will have some very important things to say because I think by the way it's not just the recommendations from Public Inquiries, it is the recommendations from HSSIB.

Q. Reviews --

A. I know you have Dr Benneyworth, it is the recommendations that the CQC make when they do their inspections of hospitals, it's -- it's all manner of recommendations, it is the recommendations that Royal Colleges make because they are very important arbiters of professional standards. So if the Royal College of Surgeons makes a recommendation about something that should happen when it comes to knee surgery, for example, where does that happen? How does that, does that get lost in the system?

So that I think is a very, very important thing that needs to be put right.

Q. Can I ask you to comment on two pieces of evidence we have heard on related topics, the first from

Sir Robert Behrens, of course the former Ombudsman. He said:

"The fact that Inquiries many years apart find the same failings is met with dismay but not always outrage or even surprise. There is almost an acceptance that this is how things are. This inertia undermines the difficult work under way to change cultures and manage patient safety more effectively."

He says in answer to the question addressing that acceptance: how can we remove the acceptance if that is the way it is? He said: well, that needs political leadership and it needs leadership in the NHS and from the Department of Health.

First of all political leadership you have mentioned there that why would clinicians accept a directive or something from the Secretary of State who has not got a clinical background. What is the leadership required? How might they accept that, for example?

A. I don't want to be -- can I answer, can I just say something else before I come on to that question because I think it's very important.

I just think in terms of context, it's important not to give the impression that progress wasn't made over this time. So I don't want to be at all defensive

because there are lots of problems in the NHS and I am not trying to gloss over it but, you know, by the time I left as Health Secretary 4 million more patients every year were being treated in "good" or "outstanding" hospitals than when I started. When I started we didn't even know where the "good" or "outstanding" hospitals were. I think the most successful safety campaign that started in my time was the Halve It Maternity Safety Campaign and by 2023 the number of neonatal deaths had fallen by 30% although I think there are some worrying signs that it may now be going in the wrong direction.

So I think it is absolutely possible to change culture and save lives.

The worry I have is what happens if you don't have a Secretary of State who is totally focused on those kinds of issues because, you know, something else happens like for example a pandemic or something. You know, it is not a criticism of the Secretary of State for having different priorities. My conclusion is that much of this discussion about medical error and medical malpractice is ultimately about the way doctors and nurses behave and if we take hospitals for a moment, it is not just hospitals, I think you have to put yourself in the shoes of the Medical Director of our 250 NHS Trusts in England and you have to think that Medical

Director is technically the most senior doctor in that Trust, they sit on the board and they are receiving hundreds of recommendations every month, possibly hundreds every week, from the CQC, from medical colleges, from NHS England, from Inquiries such as the Francis or Morecambe Bay Reports. And they couldn't possibly spend their whole time or they could spend their whole time just looking through those recommendations but then they won't be able to do their main job which is running a busy hospital, and I think what we need is something at the centre that not just catalogues these Inquiries, but priorities them perhaps with a traffic light system.

So, for example, if there's a -- I always worry that if a baby died because of something that went wrong in a hospital in Blackpool, you know, what you would hope in the NHS is that things would change in a maternity unit in Cornwall the next month so the same thing couldn't happen.

We don't have that system in place and I think what you need is a system where recommendations from Public Inquiries, recommendations, things that ministers decide, things that NHS England decide, that the CQC recommend, that HSSIB recommends, go to a group of very experienced doctors who know how you change things in

the NHS. And if they think this is a safety issue, and it needs to change this month they would send it out with a kind of green light.

If it's something that needs to change but it may be will take a year to do it, it will maybe have an amber rating and you could have a different rating a different sort of traffic light for things that are nice to do if you can but not essential.

Because I think you have to make life easier for very busy Medical Directors so they know what it is they want their clinicians to do.

So in the case of the tragedy at the Countess of Chester, I think one of the documents you asked me to look at was the Beverley Allitt case.

Q. I am going to come back to that.

A. Sorry, yes, carry on.

Q. I am going to ask you to comment on the second piece of evidence, thank you, you have responded in relation to Sir Robert Behrens' evidence.

Sir Gordon Messenger gave evidence this week and it was related specifically to an induction document and training for senior managers but he made this observation generally about directives or material being put together and he says:

"The other observation I would have is that they

are not by any means the only organisation that I have seen to do this but 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 two things and I think partially because of the problems I have outlined at the beginning they are sometimes despite 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 be more joined up."

And that would be a constructive observation.

You nod. But it sounds constructive and perhaps accurate. Would you agree with that, that the preparation in directives or change or encouraging it might more be in the documents, the written form and it needs to happen where the Medical Director and people are sighted in the hospital embedding it on the ground?

A. Exactly. But it's -- but there is quite an important journey that you go on. I don't want to pre-empt what you are going to come on to with Beverley Allitt, but can I just give one example of why I think this is something that we don't do very well.

So there was one recommendation from the Inquiry that you should raise awareness of the possibility of malicious harm, I don't know the exact words but it was

that.

Q. Heightened awareness of events at Grantham, deliberate harm?

A. Yes. In reality, that is actually a useless recommendation if you just pump it out to 250 NHS Hospital Trusts because they would -- in order to -- you know, they are very, very busy, they might just send an email round to everyone and say: you need to be aware of the risk of malicious harm in your work and doing it.

The actual way which wasn't the recommendation in the report, but the actual way that you could properly implement the spirit of that recommendation would be to say: you need to set up a system of Medical Examiners and Medical Examiners need to be trained to see the signs of malicious harm or patterns of harm that could be malicious in their work.

And that is the recommendation that you can then say make a big difference and you can also track whether it's been implemented or not and by when. And I think that translation of a well-meaning recommendation into something that can have an impact on the ground in the largest healthcare organisation in the world, which the NHS is, is the bit that's missing.

Q. So it's what you do in practice?

A. Yes because, you know, you -- and I am,

I think that, I mean, I was really responsible for setting up of HSSIB. But when it first got off the ground I didn't think its recommendations were very good when I read them because they were too woolly and what -- if you want to see lives saved you need to see specific changes in practice on the ground. That's a very difficult thing to do when you are talking about very busy obstetricians and midwives in a maternity unit, getting them to change their daily practice.

So that's why you if you are going to have a recommendation you need to talk to someone who is running those units, to work out the way you actually would implement it in practice and that needs to be what happens.

Q. Can I ask please that we have Baroness Bottomley's statement on the screen, please, INQ0107143, page 1. You have seen this earlier, Mr Hunt.

If we go to paragraph 8, so those in the room who won't have seen it, if we go to page 3 of the statement. Give people time if we can to read 8, 9, 10, 11.

A. Yes.

Q. It's paragraph 11 and moving over to the next page where Baroness Bottomley says:

"The decision to commission an Independent

Investigative Inquiry as opposed to a Public Inquiry was one made after careful consideration and having discussed the matter with my Permanent Secretary, from previous experience of investigations into child abuse I considered that in cases such as this the truth may more readily emerge in a private investigation than a public forum where witnesses may feel under a strong external pressure and the tone more adversarial. It is also important to me that the investigation be conducted timeously so that lessons could be identified and acted on and I considered that this format would better facilitate that."

This of course refers to Beverley Allitt's crimes in 1991 and her appointment of Sir Cecil Clothier to investigate what had gone wrong.

First of all, the private versus public Inquiry. There's obviously a cost implication in that but what do you see are the considerations for determining whether there should be a public or private Inquiry?

A. I mean, I did loads of both, so I think there are pros and cons. Cost is one consideration with a Public Inquiry but also time is another consideration. They take much longer.

For example, I commissioned Sir Robert Francis to do a second review into the problems facing

whistleblowers in the NHS and he did it in a year and it wasn't a Public Inquiry so he was able to do it much more quickly and I think there are times, if you really want to get on and change things quickly, where a Public Inquiry can take too long. On the other hand, I persuaded Theresa May to do the Public Inquiry into the Infected Blood Scandal and I think that was an Inquiry which needed to be public and needed to take time, even though victims were dying the whole time as a result of it.

So I agree with Virgina Bottomley's assessment in that. I think there are times when it's sensible to do something more quickly.

Q. If we go to paragraphs 15-17, which identifies that the report criticised failures of management and communication with the hospital, concluded delays in drawing together the different strands of evidence, prevented foul play from being identified sooner.

And we go over the page, please, page 6 of her statement:

"The report made 12 detailed Recommendations relating both to attitudes and procedures within the hospitals and individual and collective responses to the events."

She sets out at paragraphs 21 and 22, if we read

there, the focus groups or the expertise that she sought considering the recommendations and again as a matter of practice for the Secretary of State when you receive recommendations, what's done next in terms of evaluating them?

A. Well, what, it obviously depends to a certain extent on the Secretary of State. I'm not sure that there is necessarily a procedure laid out in statute. But when I was Secretary of State the practice would be that you would receive recommendations and make an initial response to them and then after you have had time to consider them in detail, because you might not see them before they are published or might just see them a couple of days before they are published, so it obviously takes you time to go through them in detail you then come back to Parliament, and you would say which ones you intended to implement and which ones you weren't going to implement and if not, why not.

So that I think is good practice.

Where it can go wrong is where there's a change of Secretary of State and a new Secretary of State comes in who isn't aware of the commitments made by a predecessor and sometimes recommendations can get forgotten or kicked into the long grass as a result.

Q. And if we go to page 9 of her statement,

paragraph 32, she refers to the recommendations surrounding the provision of paediatric pathology services in every case in which the death of a child is unexpected or clinically unaccountable.

And moving down the page, "Purpose of Inquiries and Recommendations", she sets out at paragraph 36:

"There may be many reasons why recommendations may not be implemented. I consider it likely that changes in ministers, Governments and those in key positions within the NHS could lead to recommendations unintentionally falling by the wayside. This is highly regrettable ..."

If we go to the next page.

" ... and the fundamental purpose of Inquiries is to learn lessons from events where there have been failings, and if so, a recommendation has been carefully considered and accepted, it should be implemented.

"I am asked to say where I consider accountability lies. In my view, formal accountability lies with the office holder to whom the recommendation is made and his or her successors in office."

Would you agree with the paragraphs at 37 and 38?

A. I would, but could you possibly go back to page 9.

Q. Yes, of course.

A. Because I just want to make a comment about paragraph 2 because I just think it illustrates how difficult this challenge is. So the recommendation there is that paediatric pathology services should be engaged in every case in which the death of a child is unexpected or clinically unaccountable. It sounds extremely sensible.

Q. Quite.

A. And I don't know how quickly that happened.

But when I was Health Secretary, I wanted to go further because I was very worried about level -- the high levels of baby deaths. If we had the same neonatal death rate as Sweden we would have 2,000 more babies living every year and I thought that was something that we needed to deal with.

So I introduced a requirement of the NHS that there should be an independent investigation into every baby death, not just the ones where they were unexpected or clinically unaccountable, but every single baby death. So going a lot further than that, that recommendation.

Then I moved on and then when I came back to the issue -- these reports by the way are talked about in your review -- in your Inquiry documents, they are called the MNSI Reports.

Q. Yes.

A. They were done by HSSIB, they are now done by the CQC and they are not working. Because what's happened is that the reports are often of a poor quality, they are done, they gather dust, they gather dust, the box is ticked but the thing that you really need to happen is not actually the report but people learning from those reports and changing clinical practice on the ground.

And that's why, and it's not easy, but you need to have a structure in place which actually sees these recommendations through and makes sure that the spirit of what they are trying to achieve is delivered and not just the box ticked.

LADY JUSTICE THIRLWALL: Can I just ask you -- I'm sorry, Ms Langdale -- I see the point that you make and you make some other observations in your statement which no doubt we will come to. But at the time, there are periods or there have been periods recently when we have had really quite a turnover of health secretaries, so not change of Government, just within the same Government.

And what, if anything, did you do when you left to try and encourage some sort of continuity in the work that you had obviously thought a great deal about and made a great deal of effort towards and there is a sort

of cut-off and you are no longer involved?

A. Well, obviously it is above my pay grade to tell prime ministers how often to do reshuffles.

LADY JUSTICE THIRLWALL: No, no, I understand that, but what actually were you able to do, if anything, to address that.

A. I wrote a book about patient safety, I became Chair of the Heath and Social Care Select Committee where I tried to follow up on a lot of these themes, so I used my position in Parliament. But I profoundly agree with you that having a minister in post for a long time makes a very big difference. I mean, I think in the schools sector, the fact that Nick Gibb was Schools Minister for nearly a decade had a very big impact on education policy and so I don't think we can realistically change the fact that prime ministers are going to want to have reshuffles and indeed governments are going to fall and so you are going to have reshuffles forced on prime ministers even if that wasn't what they wanted.

But that is why we have a Civil Service that is permanent, they are there, their job is to be that institutional memory and that's why I think you need to -- we need to think about what the structures are that we could put in place, such that a recommendation

like number 32 finds its way to actual change in practice on the ground much more quickly than currently happens.

LADY JUSTICE THIRLWALL: Thank you.

Thank you, Ms Langdale.

MS LANGDALE: My question was going to be very similar: what safeguards can be put in place to avoid that loss of knowledge across Secretary of States? This shouldn't be a political issue, should it, the governance of the NHS: we should all care about the same things; is that fair? And with the time you put in whoever replaces you from whichever party, how do we achieve safeguards to ensure momentum is maintained?

A. Well, I think on this, this specific issue, which really relates to improving clinical practice, reducing the risks of avoidable harm, or indeed intentional harm to patients, I think we do need a structure which gives absolute clarity to Medical Directors about the things that they are expected to change and by when.

I think that we should have better accountability by politicians too and I think that when it comes to Inquiry recommendations, and also Select Committee recommendations, which is another type of recommendation, at the moment, ministers have

an obligation -- I think it is a legal obligation -- to respond to recommendations, but I think that there is a kind of "get out of jail card" at the moment.

So with a Select Committee, you can make recommendations and the Department of Health replies within two months and it says: Recommendation 1 accepted, Recommendation 2 rejected for this reason, Recommendation 3 under consideration. And basically that means they just want to think about it for longer, but often that's actually a recommendation that they don't want to implement but they don't want the embarrassment of saying they are not going to implement or they can't find the money to implement.

Q. Do they only have to say under consideration once or does it come back again --

A. No.

Q. -- two, four months later, or once?

A. Once they have given their response that is it. The box is ticked. And I think a much better system, which for both for Select Committees and for responses to Public Inquiries, is if ministers were required to do, could only do one of two things: first of all, within the statutory time period they had to respond, they have to say either they are accepting and by what date they will have implemented it, or they are

rejecting but I think it's -- you know, I think there should be an obligation to transparency.

I don't think you can require ministers to accept every recommendation that is made by an independent body because there will be cost implications and they may not agree with them and ultimately they are elected representatives but I think there should be complete transparency about if they are going to implement it, when they are going to implement it by, and if they are not going to implement it, you know, truthfulness.

Q. Do you think that the House of Commons Select Committee are an appropriate mechanism for monitoring recommendations and their implementations or not?

A. They can be. Certainly when I was chairing the Health and Social Care Select Committee, doing a report on whether the Government had actually implemented the recommendations of a Public Inquiry was a perfectly sensible thing to spend time doing a report on. But it's the decision of the committee as to what to spend its time investigating.

Q. Can that document come down, please, and instead can we have the "Report recommendations but no action", INQ0108741, page 1.

This is a report. We heard, Mr Hunt, from Dr Benneyworth yesterday and this was a collaboration,

a meeting between, if we go to page 3, a number of arm's-length bodies at 3 and the top of page 4. And as the title of the report might suggest, looking at recommendations but no action, the point you have made and others have made, this plethora of recommendations, overwhelming number, what do we do? How is that streamlined for those on the ground trying to follow what's being said and what's being asked of them?

If we look at page 4 and the findings, if we can scroll up, please, Mrs Killingback, I would like your comments on these.

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

Would you agree with that?

A. Yes.

Q. The second one:

"The noise created by the significant volume of recommendations being made means that providers struggle to prioritise and implement them"?

A. Yes.

Q. That is what you have said earlier.

"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."

Is that another task for someone or do you think that is a good idea?

A. I think it's a good idea but I don't think it's enough. I think just having a database of all the recommendations in maternity safety, for example, isn't -- isn't enough. What -- what the person who's running a maternity unit needs to know is what are the safety critical things that I need to do this month in terms of every single baby being born in my unit?

And the process of doing those safety critical recommendations, you know, obviously the people doing it need to be cognisant of the fact that that person doesn't have unlimited capacity to implement unlimited changes in working practice. So you have to have a sort of self-denying ordinance that priorities the most important things. But I think at the moment there are just so many recommendations that that things just get forgotten or lost.

Q. What's the skillset of the person or people you envisage doing that, distilling the essence of the recommendations for those on the ground?

A. Well, I think they need to be the experts in NHS England who themselves have run maternity units or been obstetricians or midwives and understand --

Q. Understand the job?

A. -- the working environment so that they can make sure they -- anything they are doing isn't -- is practical.

I think there is one other way that you can come at this which I think does happen, which is also ask the CQC as part of their inspection process to see how effective hospitals are at adopting recommendations and improving working practice.

Q. Would you have the skillset that you have just described within the CQC of them knowing how that should be done with particular recommendations or would they be relying on the people they are inspecting for what they just tell them about what they are doing for that?

A. Well, I think the CQC has been going through a very difficult patch. But when I set up CQC with Professor Sir Mike Richards as the first Chief Inspector of Hospitals, his approach, which I strongly endorsed, was this a maternity unit should only be inspected by obstetricians and midwives. And the reason that his inspections were so powerful was because hospitals knew that they were being inspected in every part of the hospital by their peers, by people who knew what they were looking at.

I think that was changed a few years ago and my

understanding is it's been changed back. Professor Sir Mike has actually made a recommendation which I think the Health Secretary Wes Streeting has accepted, and so I think it's going back to a peer review system. So absolutely it's very important that, you know, GPs are inspected by people who understand general practice and hospitals and the social care sector are the same.

Q. What was your understanding -- and if you can't remember, don't say -- about CQC collection of data around 2015 to 2016, safety data around deaths and looking for signals around deaths or unusual patterns?

A. Well, the CQC, the new CQC inspection regime was only set up I think in the second half of 2013 and by the time we got to 2015 I think they had only managed one complete round of inspections of hospitals.

But they were I think rather rightly nervous of over-relying on data in their inspections because in order to get a very -- a proper assessment of the culture in an organisation, they believed -- and I agreed with them, that you need to go somewhere and feel what it's like and talk to people and over -- and data can be manipulated and an overreliance on data sometimes means that the inspectors become a bit distant.

So I am not minimising the importance of data but

if I could give you an example of the old CQC which I changed and why we were nervous about data. So the old way that we used to inspect care homes was that you would send someone in their twenties in to a care home and they would go straight into the office and they would look at the care home's data and then they would give an inspection result and that was changed to a system where people who had experience of care homes would actually go into the care home, talk to the residents, talk to the staff and make a judgement based on what they saw with their eyes and we found that was a very important way of getting to the most accurate results.

Q. If we go back to this list from the report and the various findings, the penultimate one:

"Most recommendations made to the healthcare system are not costed either in relation to the cost of implementing the proposed actions or their longer term cost-effectiveness."

Do you think there's a way that Inquiries or reviews could cost recommendations before they are made, is there any way there could be consultation about that?

A. I think that it is -- it would be a very good thing for Inquiries to take more interest in the cost of their recommendations because people running Inquiries

like yourself, my Lady, are very keen to make sure that their recommendations are implemented and often the reason that things are not implemented is because of cost. I think that was the fundamental issue with the recommendation on Medical Examiners; there was a cost involved asking every hospital in the country to allocate doctor resource to examining every death that happened in that hospital.

So I think it can give you a clue as to where there are likely to be the most difficulties in implementation.

But I think there is a bigger reason why, but I don't think you could expect Inquiries necessarily to know the costs of everything that they are opining about.

But if you had a central structure that was looking at the recommendations on patient care that were coming in from Royal Colleges and the CQC and Public Inquiries, they would know the cost because it would be, you know, part of NHS England perhaps. And I think that they would then be able to prioritise. Things that are free we should do straight away without any hesitation. Things that cost money, we should be reasonable that organisations are going to have to find resource to do it and maybe you give people a timescale within which

they have to do that and that is part of the way that we will have a more structured system where we have confidence that what we want to happen does actually happen.

Q. Do you think new recommendations should explicitly supersede previous recommendations by reviews or Inquiries if they are very specifically related?

A. I think that you would hope that if a new recommendation was made that had an impact on a previous recommendation it would be explicit that this recommendation is replacing a previous recommendation.

But I think that's why you need someone centrally aggregating all these recommendations and then making a decision as to what it's reasonable to ask a Medical Director to implement in their own hospital.

Q. When you say centrally, do you think this should be for NHS Inquiries and reviews as opposed to Public Inquiries generally. There's been some discussion, as you know, about a unit on the face of it potentially to look at Public Inquiries' recommendations or do you think the NHS has so many recommendations it is very specific and a very large organisation deserving of itself --

A. I think the solution that we came up with was just about Public Inquiries because when you look at the

NHS, there are so many other recommendations that are important from the CQC or HSSIB or, you know --

Q. NICE?

A. NICE, exactly. There so many other ones that come up so I think actually the NHS needs a single way of knowing what it's expected to do and by when with total clarity.

One innovation and I am just sort of thinking off the cuff here, I wonder whether in terms of all Public Inquiries one of the things we should do is ask the judge responsible for a Public Inquiry to do a subsequent report, maybe two years later, which formally assesses the extent to which their recommendations have been implemented.

That might be a way to jolt the system to implement stuff that's been put in the long grass and I don't think they would be able to pull the wool over the eyes of any judge so that would encourage transparency because I think it would mean that where you weren't planning on implementing a recommendation it would encourage you to say so up front and explain why. But it would perhaps make it more difficult for people to kick stuff into the long grass.

Q. Indeed that is one of the questions from our CPs: should Inquiries have the power to request the

Secretary of State for Health to provide detailed reasoning for not implementing any recommendations within 12 months of them being made?

So slightly shorter period, certainly transparent but 12 months subsequent to a report, the Secretary of State reasoning what is being implemented and what isn't and why are publicly available?

A. Yes. I mean, I don't have a particular view about the timescale. I think it will depend on the Inquiry and the nature of the recommendations. But I think it would be a good practice to have a kind of a standard rule with Public Inquiries that after a fixed timescale, the person in charge of the Inquiry gives a verdict as to whether what they have said has been taken seriously by the Government or not.

Q. If we can go, please, to page 7 of the document on the screen, "Recommendation Registers".

We see at the bottom:

"NHS has developed a National Recommendations Register for Maternity and Neonatal Services."

That presumably could be replicated in other areas, couldn't it, as well?

A. Yes. I don't know how well the National Recommendations Register for Maternity and Neonatal Services is working in the NHS at the moment. I am --

I am a bit nervous about -- I mean, I think it's a good idea to have a register but I think what really matters is what people are asked to change and by when. And just cataloguing all the different things that might be good to do isn't in my experience going to be enough.

Q. If we go back -- that can come off the screen -- to your statement, at paragraph 37, Mr Hunt, you were asked to explain the effective decision not to implement recommendations and the consequences for the Government and Government departments concerned and there is no formal sanctions.

What is your view about that, that there is no formals sanctions in those circumstances?

A. I think the way our democracy works is that accountability sits with Secretaries of State and they therefore should be the ones that make the final decision as to whether to implement a recommendation. But what I don't like is the way that it's so easy to push into the long grass recommendations that you don't want to implement and not be accountable for that.

Q. Indeed there is some scepticism in some quarters, isn't there, that setting up a Public Inquiry might be doing exactly that: pushing it down and not actually intending to do very much when the recommendations come back?

A. Yes.
Q. You nod, but what is your view about that?
A. I think that sometimes, you know, that probably is the case. I found the opposite, what I found was that, you know, not just Public Inquiries but when I commissioned Inquiries, it was a forcing mechanism. I was -- you know, because obviously if you choose someone who's respected to do the Inquiry, as for example Sir Robert Francis was, then his recommendations carry a lot of weight and I was very keen to change the culture in the NHS to be more of a learning culture and I found that having clear recommendations from Sir Robert made that much easier.
So his Freedom to Speak Up Report that he did recommended that we have Freedom to Speak Up Guardians in every hospital which is an independent person any doctor or nurse can contact if they have concerns about patient safety and the way they are being asked to do things. That actually has been one of the most successful things that's happened in the NHS in the last 10 years, I think it's broadly been a successful reform, unlike the independent report on every child death which has -- I think it can be a very important reform and I hope we make it work but I don't think it has been successful to date.

So I think those Inquiries are good ways of making stuff happen.
Q. You refer at paragraph 49 in 2015 to the publishing of "Learning Not Blaming" and it's clear it's important not to stigmatise for mistakes, isn't it, particularly when they are part of a collective failure and there needs to be a system change? But in those rare cases where deliberate harm has been caused by someone, it is very different, isn't it? There is a need to be responsible and blame in some cases?
A. (Nods)
Q. Again you nod, but how do you differentiate between the two, how do you know on the ground which you are dealing with?
A. Well, I -- it's obviously a difficult challenge but I think it's completely solvable. And I think the key here is openness and transparency and the -- I think one of the problems at the moment is that if a doctor makes a mistake they are worried that if they are open about that mistake, they will lose their job because in the end it's easier for a hospital to fire a doctor and say: I am very sorry about what happened but we had a rotten apple but we have got rid of him or her, than to change working practice on the ground.

And, you know, in every other field -- not every other field but in most other fields, in your field and my field we make mistakes the whole time but someone doesn't die.
If you make a mistake and someone dies it is an incredibly difficult thing but most -- most -- nearly all doctors I have ever met all they want to do when that happens is to learn from what went wrong and make sure that they and their colleagues never make the same mistake again.
If, as happens for example, when babies die on maternity units the lawyers are called in, there is a five or six or seven-year period of litigation because the parents, quite understandably, want to get a big financial settlement if they have got to bring up, for example, a disabled child with enormous cost, doctors are worried about their professional reputation, battle-lines are drawn, and even five years later when a court decides what actually happened, often very little is learned or changed on the ground because everyone says "that's something that happened five years ago" and we have to change that culture.
But because there is so much of that happening, as I say I think 13,500 preventable deaths every year in the NHS, by the way, that is about the average

internationally, so this is not just an NHS theme, when you have the egregious cases, the Shipmans or the Letbys, they are less likely to get spotted in a context where there is so much other preventable death that is going on.
At the same time, of course, I think it's very important that Medical Examiners understand that tragically once in a while there will be malicious actors and you have to have that in the back of your mind the whole time.
But I think it would be much, they would become much more apparent much more quickly if we had better structures in place for dealing with the majority of deaths which are actually caused by error by people who are really trying their hardest.
Q. And you indeed say at paragraph 64 you would recommend moving to a no fault compensation scheme. Would you like to elaborate upon that?
A. Yes. I mean, there are, you know, countries like Sweden and New Zealand have been able to foster a much more transparent culture by saying to -- in the case of Sweden, if they make an assessment that somebody has been harmed because of medical error, compensation is automatic without having to go through a legal process and without having to attach blame to

an individual doctor. And they take the sting out of those problems and they have a much more transparent culture and as I say, a safer culture because fewer babies die than happens in UK.

In New Zealand they have gone even further and they just have a menu of compensation that is paid to people who are harmed in the system.

Those systems actually, I looked at that system when I was Health Secretary and I was told by my officials that it was more expensive because most people don't claim for -- when they are harmed by the NHS. Under that sort of system you would automatically pay everyone who is harmed. It actually turns out it costs New Zealand less than clinical negligence costs us here.

LADY JUSTICE THIRLWALL: Pro rata or?

A. As a proportion of the cost of the healthcare system.

LADY JUSTICE THIRLWALL: Right, okay.

A. We pay more --

LADY JUSTICE THIRLWALL: Yes.

A. -- for our system than New Zealand pays with its menu-based no fault system.

MS LANGDALE: You say in your statement -- your final paragraph says:

"... when it comes to the implementation of

recommendations, whether statutory or not, I recommend a beefed-up version of the requirements placed on governments to respond in a timely way to Select Committee reports, the government should have an obligation to respond within 60 days to all recommendations with a straight 'yes' or 'no' answer."

Accept no "under consideration" type principle?

A. I would just add to that I think if they say yes, they need to give a date by when because otherwise again it can be just delayed and delayed and delayed.

Q. What about -- we have seen you have done it with the other reviews you have commissioned, and Baroness Bottomley did it in discussion groups what about if you need to follow up or have further discussions with affected parties giving dates for that ie timetabling anything they intend to do?

A. Yes, absolutely.

Q. Finally, we asked for any reflections on enhancing the safety of babies in hospital generally. This Inquiry is looking at the wider NHS and particularly looking at babies.

Do you have any comments about that that you would like to make? I don't mean detailed policies but general views or from your experience what you would say keeping babies safe in hospital and with a particular

eye perhaps to the deliberate acts of harm?

A. Maternity safety was always one of the areas I was most concerned about. You know, the clinical negligence settlements cost the NHS about £4.5 billion every year which is money that is not being spent on doctors and nurses but compensating families for harm that should not have happened and I think that it's an area that we should continue to do more on.

We made good progress I think in the second half of the last decade, but over the last few years I think because the NHS has been under so much pressure with the pandemic, the indicators have started to go back again in the wrong direction and I think it would be -- I think it should be a very big priority. I think it is a priority, by the way, for the current Health Secretary, to renew effort on maternity safety, but it's not just maternity safety.

You know, the safety of patients having hip and knee replacements, the safety of patients in general practice who get a wrong diagnosis. These are all areas and I would say that in the end they come back to culture and whether you have an open and transparent learning culture where doctors feel able to discuss mistakes they may have made and confident that if they do that, they will be treated fairly and that's the

thing that fundamentally is the issue that we need to address.

Q. And how are doctors to be made to be feel valued in the system because that is clearly important for a culture, isn't it, to feel valued and respected?

A. Well, I think that if you look in the NHS you can see brilliant hospitals where they have exactly the right culture and that happens. I mean, Salford Royal was particularly well known for it, Worthing and Chichester Hospitals had a brilliant learning culture when I was Health Secretary.

Q. How was that done? What did you observe, how did they achieve that, do you think?

A. When I visited Worthing Hospital, I remember being taken to an upstairs room where there was a wall of Post-It notes which were suggestions from clinicians as to how they could improve the care they were giving to patients, so it's -- I think one of the most impressive hospitals in the world is Virginia Mason Hospital in Seattle, it is very famous for its safety culture and they were the best I ever saw in terms of creating a supportive culture in which clinicians feel able to speak if they made mistakes. And we set up a collaboration with Virginia Mason and I think they coached about eight NHS hospitals in how you get that

culture right.
I don't think you can impose culture from the top, I don't think you can have a Health Secretary or a Chief Executive of NHS England who says, you know, "thou shalt be open, thou shalt be supportive to people who talk about", it's something that has to come from inside.
Q. Inside the hospital, leaders at all levels?
A. Absolutely, it needs to come from the leader, the Chief Executive and the board of the hospital and the people running all the different departments in the hospital but it has to come from inside.
In the end, if you are going to have the confidence to be open and transparent you have to see your line manager behaving in that way and that line manager has to see their line manager behaving in that way. So it, it needs to be fostered from the, from the very bottom up.
Q. Do you think there is any sign of an ability to take constructive criticism, you speak of performance management, people do, but discussion amongst clinicians across people working in a hospital in a reflective way where you might be getting things wrong. Are those important features of day-to-day working in an open culture?
A. They are and the best hospitals in the country

and the best hospitals in the world absolutely have that and to go back to your earlier point, I suspect that if you have that constructive culture, you would spot a malign actor much more quickly because what happens in those hospitals is that they are constantly looking at patterns and data and saying: how can we learn how can we improve this? So if you identified a high number of fatalities where patients under the responsibility of a particular doctor or a particular nurse then they very quickly talk to that person to try and understand what's happened.
And so I think it would be -- we would be much more likely to spot malign actors more quickly.
MS LANGDALE: Thank you, Mr Hunt. Those are my questions. I am not expecting any but ... there are a couple. Thank you.
LADY JUSTICE THIRLWALL: Mr Sharghy.

Questions by MR SHARGHY

MR SHARGHY: Mr Hunt, good afternoon, I ask questions on behalf of one of the Family groups involved in this Inquiry. And I would like to pick up if I may in relation to shortly after you became Secretary of State for Health and you received Sir Robert Francis's Report, I think you say in your witness statement about six months into your tenure, you say at paragraph 17 of

your witness statement that although the report was very specific to the events that happened at Mid Staffordshire you felt that the whole health and care system needed to listen, reflect and act in relation to the key challenges of culture and behaviour that the report highlighted.
My reading of that statement that you have made is that you believed that there were other wider issues and problems in terms of culture and behaviour -- and by that I am going to insert the word "negative" before each -- within the NHS and the healthcare sector widely; Is that correct?
A. Correct.
Q. In relation to that culture, this Inquiry has heard a lot of information from those clinicians who were working at the Countess of Chester at the time and others who have been involved within the healthcare sector more generally.
The challenges are partly to do with attitudes of management and you have used the examples fairly recently of the hospital in Seattle which was possibly you said the best.
But one of the other themes that has developed in the evidence is that part of the problem with culture and behaviour arises from the structure which has

developed throughout the NHS, too many committees, not enough time for clinicians to devote their efforts towards the clinical side of their role as opposed to the management side of their role.
How much of that was on your radar during your tenure as Secretary of State?
A. Well, I -- I very much agree with that and I came to realise that there were some big problems in the structures of the NHS that made it difficult to develop the constructive culture that I felt we needed. And in particular, I think there are too many targets. And I think that if you look at what is different about the way the NHS runs to nearly every other healthcare system in the world, it will be that a Chief Executive of a hospital will be assessed against possibly 100 targets every year and they spend a lot of their time trying to tick boxes to show that they are hitting a particular target in this department or a particular target in that department, and frankly it means they are rushed off their feet and they are worried about the numbers that they are going to be giving to NHS England the next month and it crowds out the opportunity for longer term strategic changes, including improving the culture. But not just that, things like putting in place a new IT system which could transform efficiency

in the organisation that, kind of thing, tends to get crowded out because they are being kept on such a short leash by their managers in NHS England and I do think that is culturally very bad for the NHS.

Q. Those targets have been consistent for the last several decades. What's the solution?

A. To get rid of them. I think that we have a much better system in the way we regulate our schools than the way we regulate our hospitals. We don't give the Education Secretary a national target for the number of physics A Level passes but if we did, the Department for Education would be on the phone to every secondary school in the country hassling them to get more people to study physics and you create a huge bureaucracy, which is basically what NHS England is.

I think, you know, we have the CQC. If it -- if it's got back on its feet, which I am sure it will be, it goes round and looks at safety, quality, responsiveness. But I think the targets that we have are -- make it very difficult to develop a patient-focused culture because people are much more interested in managing up than managing down.

Q. Thank you.

You were taken to the chronology regarding Medical Examiners by Ms Langdale and I am not going to take you

through the detail but we are talking about a 21-year period from when the recommendation is first mentioned by Dame Janet Smith to when it's fully implemented.

Within that time, we have had eight prime ministers including the current incumbent and 12 Health Secretaries, I think yourself being the longest in post. In relation to just that one recommendation, you have accepted that that is an inordinately long period not to say that progress wasn't made. But doesn't that make it even more feasible to have an independent body that oversees the myriad of recommendations that come from Public Inquiries HSSIC, Coroners I think is another one that can be mentioned. They produce Rule 28 reports all the time suggesting recommendations and it deals with a baby harmed in Blackpool, learning lessons in Cornwall so that the same thing doesn't happen again.

Do you agree with that proposal, so that there is an independent oversight body that can amalgamate the thousands of recommendations that are made, that can monitor implementation, that can look at alternatives, cost benefit analysis and then perhaps present that to the Health Secretary of the day and have carriage of challenging, if necessary, where implementation is delayed or indeed not carried out?

A. I -- I would tweak that suggestion actually.

I don't, I completely understand why people might support it. But I don't think it quite works to have an independent body because the issue is really about implementation and it's making change happen and an independent body isn't able to make change happen in the way that NHS England can.

So I would I think the body that decides on whether these -- first of all ministers need to decide which recommendations they are going to accept and the minister having decided which recommendations they are going to accept, then you need people who understand what happens on the ground in the NHS to decide how that recommendation is going to be implemented and I think that needs to be part of the NHS management structures because they are the people who have Executive authority over hospitals and GP surgeries and so on.

But I think the way that you achieve the result you want is that what they say should be transparent. I think everyone should know.

I think, my Lady, if you make a recommendation that ends up being something that you want changed in every hospital in the country, you should be able to see that the minister accepted it, then that went to this Management Team in NHS England and they said: we agree and we are going to make that happen by November 2026,

and all hospitals will be asked to do that by November 2026 and then there's complete transparency and everyone knows where they stand.

If it was a very expensive recommendation it might be that the decision was to implement it by November 2028 and everyone knows where they stand and there is honesty and transparency, I think that is the way that I would do it.

Q. Presumably one of the most persuasive things to a Health Secretary is whether or not a recommendation that an Inquiry or another organisation makes is in relation to an isolated issue or incident or whether these problems have arisen not just in the past but elsewhere and it's that which I was more focusing on than an independent body can amalgamate because at the moment, as far as I understand, there is no single organisation or body that looks at the entirety of the recommendations that come from the different sources to see how widespread a particular issue or problem is, to then try and persuade a Secretary of State that this issue is quite prevalent, it is immediate and action needs to be taken.

A. Well, I think that should be the job of HSSIB, I mean, they are an independent investigations body, they have autonomy over what they investigate and where

they think that there is clinical practice that is wrong and causing harm have the ability to launch an investigation and I think when they make a recommendation as a result of those investigations, it should then go to this transparent group of people in NHS England who say if the minister said this is going to happen, this is when it is going to happen and this is how it is going to happen and we are sending the instructions to hospitals to do (a), (b) and (c) and that is the bit of the process that's not happening at the moment.

Q. Thank you. The Inquiry has also heard a lot of evidence in relation to what we have referred to as corporate memory, I think you refer to it as institutional memory, do you also accept there is such a thing as political memory; in other words, the Government of the day, as Secretary of State, the priorities that they bring to healthcare issues in particular. Is there any way that there could be better continuity in relation to political memory?

A. It's difficult because, you know, we are a democracy and Prime Ministers lose the support of the House of Commons and then they resign and there's -- I think there's always in a democracy going to be an element of political turbulence.

I do think that where we have had the best results in terms of improving public services has been where people have stayed put for a long time and so I, you know, were any Prime Minister to ask me I would say try to keep your ministers in post for a long period of time if you possibly can because that is how you get the best results. But I think that we should recognise there will be chopping and changing in Westminster, that is part of our system and therefore we need to have structures outside the politicians who have ultimate responsibility to make sure that there is that institutional memory.

Q. Thank you. Final question. If you were able to have your time again, what is the one aspect of patient safety that you would seek to implement?

A. I wish I had done more to dismantle targets because I think they make the NHS the most centralised system in the world and they create the wrong culture. Everyone is trying to please their manager in NHS England.

I wasn't hitting my targets when it came to A&E and elective waiting times. So I thought if I scrap targets now everyone will think it is because I am not hitting them, so my plan was to hit the targets and then scrap them and unfortunately I never got to the point of being

able to do that but I think if you were going to do one thing that made the culture of the NHS more patient-focused it would be to get rid of this huge number of centralised targets that we have.

MR SHARGHY: Thank you.

My Lady, thank you.

Questions by LADY JUSTICE THIRLWALL

LADY JUSTICE THIRLWALL: Thank you.

Did you say more than a hundred targets each year?

A. Yes. I mean it's -- you know, they will have a whole bunch in their cancer unit, in the A&E and the elective care and, you know, it's -- and GPs have got about 80 through their QOF system. So we have gone target-mad in the NHS.

LADY JUSTICE THIRLWALL: And the reason for that being? What do people think targets achieve?

A. It started with Tony Blair.

LADY JUSTICE THIRLWALL: I don't -- sorry, I hope you don't think me impertinent, I don't want a great long history, it's more --

A. No, no, I will give you a brief answer.

LADY JUSTICE THIRLWALL: All right.

A. He wanted to improve the NHS and very reasonably said: we are going to have a target for A&E and a target for elective waiting times.

LADY JUSTICE THIRLWALL: So about waiting times, yes.

A. And this is the way I am going to grip the system. But since then, it's been rolled out every other area and every new Health Secretary has come in with their own set of targets, including we with patient safety targets.

So I wasn't completely innocent of this. So that's why it's become incredibly unwieldy.

LADY JUSTICE THIRLWALL: Thank you. You are not the first person, I have to say, to say that the suggestion might be to get rid of targets as a general proposition.

Going back to the point you were making about culture earlier and saying that can't be dictated by the Secretary of State or indeed a Government minister, but is there not something in the suggestion that the Secretary of State might set the tone for culture because one of the things one does observe is a sort of culture of fear that everyone is afraid of the person above them so even the people -- or not all of the people but many of the people at the top are afraid of what the Secretary of State is going to make of things.

So isn't there some responsibility within the Secretary of State and the other ministers for setting

the tone for culture?
A. I think there is more than some responsibility, they have an absolute duty to set an example.
LADY JUSTICE THIRLWALL: Yes.
A. But -- and you have to set an example but in the end, you can't change things like culture by diktat.
LADY JUSTICE THIRLWALL: That I completely understand.
A. I think one of the problems is that politicians in particular find it very difficult to accept blame because we are punished so heavily in the media if -- if we were to -- if Keir Starmer were to get up tomorrow and say "I think I got this wrong and that wrong in the last six months" you can imagine the huge ^ media furore there would be and so we find it very difficult.
But I think we should find ways to make it easier for doctors and managers in the NHS because they are not elected politicians and they should be supported to be open and transparent in a way politicians perhaps can't be.
LADY JUSTICE THIRLWALL: Yes. Thank you. Going back to Medical Examiners, and we have rehearsed the timetable, I just want to, if I can, pinpoint it a bit

more precisely.
You said it came across your desk in 2023 when you were back as Chancellor, I think that was 2022 was it?
A. I became Chancellor in October 2022.
LADY JUSTICE THIRLWALL: October 22 and 2023 was when it came back over your desk. And it was something you told us that the NHS didn't want so I just wondered in what circumstances it came across your desk?
A. Well, when I say the NHS didn't want, I think it's important to say that I am sure the NHS thought it would be an excellent thing to have Medical Examiners. But the issue was the cost of it and whether that money would have to be diverted from other priority areas and also the capacity, the number of the doctor hours available and whether, if you were going to be asking doctors to be Medical Examiners, that would mean they weren't available to treat patients with.
LADY JUSTICE THIRLWALL: Yes, and you have explained that earlier. But the bottom line was it hadn't happened and so far the NHS didn't want it to happen for all those reasons.
A. Yes.
LADY JUSTICE THIRLWALL: But then a time comes when it comes across your desk in 2023. Was that after the conviction of Lucy Letby?

A. I don't think it was related to the Letby conviction. It was because it was something that I wanted to do for reasons of patient safety.
LADY JUSTICE THIRLWALL: No, I understand why you wanted to do it but I am trying to work out why it came across your desk in 2023.
A. Because I was aware that it was a recommendation that had not been implemented because the Treasury had concerns about the cost of it.
LADY JUSTICE THIRLWALL: Right. So what happened, you said "I want this implemented", so it didn't come across your desk; you instigated it.
A. Yes, I instigated it but I -- and I can't, my Lady, I'm afraid exactly remember when but I suspect it was part of a package of other financial support for the NHS which I said this needs to be part of.
LADY JUSTICE THIRLWALL: All right, so that's 2023 and how much was involved, how much money did it cost because you said you made the money available.
A. I'm afraid I can't remember. If I were to guess, it would be something like £40 million a year. But I think it's something that we should perhaps ask the civil servants to tell us.
LADY JUSTICE THIRLWALL: Yes, I am sure we could ask somebody, but just in case you remembered it, but it

is in the tens of millions which was made available --
A. Yes.
LADY JUSTICE THIRLWALL: -- presumably to set the thing up and then that continued while you were Chancellor anyway to be included in the NHS budget.
A. I think it started from sort of 2024, didn't it?
LADY JUSTICE THIRLWALL: Yes, well, I think the legislation became effective on the day we started this Inquiry. I think that was entirely by coincidence, it was 9 September of last year.
MS LANGDALE: I think the framework, my Lady, was -- came in in October 2023 and in statutory force in September, that's right.
LADY JUSTICE THIRLWALL: Thank you. I am just going to go back to the question of your discussions with Sir Robert Francis because the general approach, as you know, as the Chair signs a report, it goes to the minister and goes to Parliament and that's the end of the involvement of the Chair.
But it sounds as though you clearly did have an ongoing discussion. Was that something that was formal or was it something that Sir Robert was doing voluntarily? How did that come about?
A. He was doing it voluntarily.

LADY JUSTICE THIRLWALL: Yes.

A. Because he was very keen to see his recommendations implemented.

LADY JUSTICE THIRLWALL: To see it through, I understand that. And you were of course open to that so of course a different Secretary of State who wasn't so keen on whatever recommendations were made, I don't mean necessarily in this context but you would not necessarily assume that you would have that sort of relationship between the Secretary of State and the writer of a report, it would depend on the recommendations I suppose and the people --

A. That's why I wonder if there was a formal obligation on the person chairing the Inquiry to make a public statement a period of time later, that might excite interest.

LADY JUSTICE THIRLWALL: Yes, and it may give a framework for that sort of discussion.

Yes, the other thing you mentioned, we haven't really touched on it today, but in your statement was the difficulty of having any testing of recommendations before the report.

I have to say that because there were suggestions made by parents in this case for example in relation to CCTV, that is something that everyone has been asked

about including NHS England and we have got their response to that.

So to some extent anyway we have looked at the practicability of some of the suggestions.

Going back to the point that you have made about having a bespoke unit, if you like, whose responsibility it is to respond to and deal with recommendations, and I understand what you say about the fact that it ought to be internal to the NHS, ie people who know the NHS well and are able to understand what the problems are.

How realistic is it, I mean, if we just rewind to the clinical examiners, the Medical Examiners point and we know that the expense was such that that wasn't something that the NHS wanted to push until -- and obviously they were very happy to push it, I am sure once you made the money available. But what about the mindset that is always: I understand why this can happen but it's super-cautious about doing anything which is going to cost money because of the knock-on effects elsewhere in the system. How would you guard against that? Because it's difficult to see that Medical Examiners were other than a really good idea.

A. So I think what I would do is this: you know, you have a recommendation for Medical Examiners. The minister has a statutory obligation to respond to that

recommendation within let's say a year or, let's say a year and to say if they are going to say either yes or no and if it's yes, by when.

So there is transparency and there is a political commitment at that point that this will be in place by a certain time. It would then go to the NHS England who having had that and if it costs money the minister will have had to find the money to do that.

It would then go to NHS England who would then give the instructions to Trusts as to precisely what they need to do by when. But I don't think you can avoid the fact that there will always be difficult calls to be made over money. I think that what we can do better than we are doing now is to create a transparency so that when ministers decide things aren't affordable they are open about it rather than just shuffling it to the right.

LADY JUSTICE THIRLWALL: Going back to the point about money. There are as you have said a lot of targets and a lot of time and effort and therefore money is being spent chasing the targets and should I infer from what you have said that if we get rid of targets that will free up a lot of time?

A. Yes.

LADY JUSTICE THIRLWALL: It won't leave the time

empty, but it will leave time for other things to be dealt with?

A. That, that's what I believe. To be clear, I think it's a very good thing that the Government is prioritising bringing down waiting times, you know, they are too long.

LADY JUSTICE THIRLWALL: Yes.

A. So I am not wanting any fewer people to be treated.

LADY JUSTICE THIRLWALL: No.

A. But I would rather that was monitored on a hospital by hospital level and with hospitals assessed transparently by the CQC as to whether they are doing as good a job as they could and treating as many people as quickly as they can. What worries me is that so much management, a lot of these targets are monthly targets and they absorb a huge amount of focus from the people running hospitals and it makes it very hard for them to focus on things like improving culture or clinical practice so I hope it would free up time for more strategic longer-term thinking by the people responsible for hospitals.

LADY JUSTICE THIRLWALL: And would that change, I mean your description of the man from NHS England hassling people on the phone about their targets. That

doesn't seem to me to necessarily engender a great relationship between NHS England and the hospitals or the GPs, whoever it is. I mean, is that a reasonable inference to draw from your description?

A. Yes, I just think it makes the whole system very short term and makes it means it's continually running hot and we need a system where things like culture are able to be thought of in the way that I think happens in other hospitals in other countries. I don't want to over-exaggerate and I think in some ways having one or two targets is absolutely fine.

LADY JUSTICE THIRLWALL: I understand that, yes.

A. That allows for people to focus on addressing a national objective that an elected politician wants. But I think it's gone too far in the system that we have at the moment.

LADY JUSTICE THIRLWALL: Thank you. Then going back to the other point that you were making and that again is something we heard about from Sir Gordon Messenger yesterday, these almost universal complaints that the centre is pumping out endless directions so they end up with so many priorities they can't prioritise or don't prioritise anything, and one of the academics, Professor Dixon-Woods, described it as a "priority thicket" which was a very vivid description.

Now, I think your suggestion is that there should be -- is it a group of people sort of who would then advise Medical Directors in particular, you know, these are the things that you ought to be -- where would those people be drawn from?

A. So just to be clear. I am, I am talking about clinical practice.

LADY JUSTICE THIRLWALL: Yes.

A. And my perspective has always been the reduction of medical error. So this could well be a structure or an approach that is important in other elements of NHS management.

LADY JUSTICE THIRLWALL: You are talking about for Medical Directors, aren't you?

A. But I am talking about what doctors and nurses do at the coalface when they are looking after patients and I think that the person that is responsible for them in hospitals is the Medical Director and I think we should be thinking what is a reasonable amount of things that one can ask a busy Medical Director to change on a monthly or annual basis. And then someone at the centre needs to be saying: look, we have had these recommendation from the Royal College of Paediatricians and we have had this recommendation from the Francis Inquiry and this recommendation from HSSIB and I have

looked at all of these and these -- these five in terms of my missive to you this month are things that it would be good to do if you can. They are positive things that will make a difference.

But this one you really must do within the next 30 days because it doesn't cost any money and it's going to save lives and I don't think anyone is thinking that way and I think it's just basic management that when it comes to clinical practice and things that would save lives, we don't have a way at the moment, if there was a different way of delivering a baby that was proven to save lives and we should change to it straight away, we don't really seem to have a way of making that happen.

LADY JUSTICE THIRLWALL: Yes. So what I was asking you though, who would be the person or the people who would carry out that work?

A. I think it should be under the direction of the Medical Director for NHS England, Sir Stephen Powis, that would be my -- he would be the right person. I think he would understand and be able to make a judgement as to how much it was reasonable to ask Medical Directors to do on a monthly basis in terms of improving safety and quality.

LADY JUSTICE THIRLWALL: I was rather hoping you would say him because he is giving evidence next week.

A. He may totally disagree, by the way.

LADY JUSTICE THIRLWALL: He may do.

Those are all my questions. Does anybody want to ask anything arising out of those? No. I'm sorry we have kept you a bit longer than we promised but not too long. Thank you very much indeed, Mr Hunt, you are free to go.

A. Thank you, my Lady, thank you, Ms Langdale.

LADY JUSTICE THIRLWALL: So that concludes the evidence for this week?

MS LANGDALE: That's right, my Lady.

LADY JUSTICE THIRLWALL: And I think we are sitting next Monday aren't we?

MS LANGDALE: We are, 10 o'clock.

LADY JUSTICE THIRLWALL: 10 o'clock next Monday.

Thank you very much all very much. See you next Monday.

(4.45 pm)

(The Inquiry adjourned until 10.00 am on Monday, 13 January 2025)

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