

Thursday, 9 January 2025

1
2 (9.30 am)
3 **LADY JUSTICE THIRLWALL:** Mr De La Poer.
4 **MR DE LA POER:** My Lady, our first witness today is
5 Tracy Bullock. I wonder if Ms Bullock would be kind
6 enough to come forward, please.
7 **LADY JUSTICE THIRLWALL:** Please.
8 MS TRACY BULLOCK (sworn)
9 Questions by MR DE LA POER
10 **LADY JUSTICE THIRLWALL:** Do sit down. Yes.
11 **MR DE LA POER:** Please could you give us your full
12 name?
13 **A.** Tracy Ann Bullock.
14 **Q.** Ms Bullock, is it correct that on 29 May of
15 last year, you provided to the Inquiry a witness
16 statement?
17 **A.** I did, yes.
18 **Q.** And is the content of that statement true to
19 the best of your knowledge and belief?
20 **A.** It is, although I have just spotted one error
21 on page 4 and paragraph 17 and it states that my
22 employment was from 1999 to 2004 at Bolton Hospital, it
23 should be 2002. It is correct on previous pages.
24 **Q.** Thank you very much for that correction. But
25 for that, is the content of the statement --

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1 **A.** I did, yes.
2 **Q.** In terms of your main job, did you join the
3 Mid Cheshire Hospitals NHS Foundation Trust in 2006 as
4 the Director of Nursing and Patient Experience?
5 **A.** Yes, I did.
6 **Q.** And did you subsequently become the Chief
7 Executive of that Trust from October 2010?
8 **A.** Yes.
9 **Q.** And just to conclude your career, following
10 that, were you employed at the University Hospital of
11 North Midlands NHS Trust as the Chief Executive there?
12 **A.** I was, yes.
13 **Q.** And just to give us the dates, when did you
14 move from Mid Cheshire to North Midlands?
15 **A.** I started on 1 April 2019.
16 **Q.** And did you continue in that role until your
17 retirement on 30 June of 2024?
18 **A.** I did, yes.
19 **Q.** And in fact, some 12 days before that
20 retirement date, did that mark 40 years of work in the
21 NHS?
22 **A.** It did, yes.
23 **Q.** Now, in terms of what we are going to deal
24 with in your statement, the first thing I would like to
25 ask you about is your experience and knowledge of the

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1 **A.** It is.
2 **Q.** -- true to the best of your knowledge and
3 belief?
4 Thank you very much indeed. We will briefly
5 introduce you by way of beginning your evidence and I am
6 just taking this from the first three or four paragraphs
7 of your statement.
8 Did you begin training as a nurse in 1984 and
9 subsequently qualify in 1987?
10 **A.** I did, yes.
11 **Q.** Did you then hold a number of nursing
12 positions, including positions of nurse management?
13 **A.** Yes.
14 **Q.** In 1999, did you become the Clinical Risk
15 Manager at Bolton Hospital?
16 **A.** I did.
17 **Q.** In 2002, did you join a newly formed national
18 team as the Associate Director within the Modernisation
19 Agency and subsequently the Department of Health?
20 **A.** I did.
21 **Q.** And covering a period of nearly two decades
22 from 2000 through to 2019, did you also hold at various
23 times a seconded role with either the Commission for
24 Healthcare Improvement, the Healthcare Commission, or
25 the Care Quality Commission?

2

1 Clothier Report which you deal with at paragraph 19.
2 Now, was that a report that you were aware of at around
3 the time that it was published?
4 **A.** No, no, I became aware of that when I became
5 the Clinical Risk Manager.
6 **Q.** I am so sorry, I am sure it must be me: can
7 I just ask you to keep your voice up, it is a very large
8 room?
9 **A.** Yes, sure.
10 **Q.** Approximately what date was that?
11 **A.** So probably in 2000, early 2000 when I was
12 into the role of a Clinical Risk Manager, I went to
13 network meetings with other Clinical Risk Managers and
14 this was a new role at Bolton, there was no predecessor,
15 no way of doing that role so I had to learn from other
16 people who were already doing that role in, in the NHS
17 organisations and this was one of the reports that was
18 particularly mentioned to me.
19 I was unfamiliar with it at the time and wasn't
20 aware that Bolton Hospital at that time had done
21 anything in relation to that report so I sought it out
22 and read the report.
23 **Q.** And what were the main takeaways for you from
24 that report?
25 **A.** I think the main things for me were culture,

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

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

11 **A.** Yes, yes.

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

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

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

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

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

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

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

22 **A.** Mmm.

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

25 **A.** Yes.

7

1 the point you are making?

2 **A.** Yes.

3 **Q.** This is an extremely infrequent occurrence?

4 **A.** Yes.

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

9 **A.** Yes.

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

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

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

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

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

5 **A.** Yes.

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

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

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

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1 need to go and speak to.

2 But in the more serious of cases we would go to,
3 and these are not necessarily linear, you wouldn't go to
4 the police then the CQC then the ICB. These would be
5 done in parallel and could be done in parallel so

6 I might ring the police, where the Chief Nurse would
7 likely ring the CQC as she would have that relationship
8 with the CQC, the Medical Director might take a role.

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

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

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

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

9

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

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

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

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

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

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1 back to them at a future date.

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

6 **A.** Yes.

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

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

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

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

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

25 **A.** I think the next time that I recall seeing

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

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

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

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

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

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

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

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

25 **A.** I would probably say at one of the regional

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

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

5 **A.** Yes.

6 **Q.** Were there conversations before 2017 --

7 **A.** Yes.

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

10 **A.** Yes. Yes. There were. So firstly what
11 I would say is when -- when Tony Chambers was applying
12 for the role at the Countess of Chester, I became aware
13 of that because he contacted me just to seek advice on
14 the Cheshire and Merseyside region and Mid Cheshire's
15 working relationship with the Countess of Chester.
16 So we had a number of phone calls there prior to
17 him going for his interview. Then once he was appointed
18 as the Chief Executive at the Countess of Chester, again
19 I would see him regularly at the Chief Executive
20 meetings and there would be ad hoc phone calls. If
21 I was aware that he was doing something interesting in
22 his organisation, or vice versa, we would ring each
23 other to see what was happening.

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

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

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

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

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

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

9 **Q.** So am I right in thinking that when we get to
10 2017, there had been a number of occasions when you had
11 spoken as Chief Executives?

12 **A.** Yes.

13 **Q.** Whether one to one for advice or support?

14 **A.** Yes.

15 **Q.** Also in a larger group setting --

16 **A.** Yes.

17 **Q.** -- of Chief Executives.

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

19 **A.** Yes.

20 **Q.** And he was Countess of Chester?

21 **A.** Yes.

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

25 **A.** No. Quite the opposite, actually.

14

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

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

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

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

11 **Q.** Does it surprise you knowing what you know now
12 that particularly given the timeline, namely that all
13 the way there was an increase between mid-2015 to
14 mid-2016, there was then an internal review, the
15 Royal College came in all of this in the back end of
16 2016, so a lot of activity around it, does it surprise
17 you that that information hadn't reached you?

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

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

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

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

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

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

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

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

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

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

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

20 **A.** Yes.

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

19

1 unusual.

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

7 **A.** In all honesty probably not.

8 **Q.** And so your recollection is a telephone call?

9 **A.** Yes.

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

11 **A.** Him to me.

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

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

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

18

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

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

12 **A.** It did.

13 **Q.** Who brought Dr McGuigan's name up?

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

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

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

5 **Q.** Now, was the police mentioned?

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

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

17 **Q.** The question was whether the police was
 18 mentioned?

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

21

1 have concerns about a particular individual?

2 **A.** Mmm.

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

6 **A.** Yes.

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

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

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

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

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

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

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

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

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

19 **A.** Yes.

20 **Q.** Got good judgment?

21 **A.** Yes.

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

22

1 driving it.

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

8 **A.** Yes.

9 **Q.** If it wasn't that they suspected harm by that
 10 individual that they had identified?

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

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

20 **A.** Yes.

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

23 **A.** It is, yes.

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

24

1 seriously?

2 **A.** Yes, absolutely.

3 **Q.** Did you say to Mr Chambers: look, if
4 Dr McGuigan thinks that, I really think you need to call
5 the police?

6 **A.** The conversation almost went around those
7 lines because by then, as I said, there were those half
8 a dozen or so things that had already been done and he
9 felt that the only avenue that was left was the police
10 and we did discuss that and you know, like I said, he
11 wasn't adverse to contacting the police that I recall.

12 **Q.** But if the only avenue left is calling the
13 police and that is the thing that the Consultants wants,
14 there is no conflict, is there?

15 **A.** No.

16 **Q.** And yet your perception was that this was
17 a situation of conflict?

18 **A.** Yes. I think from what I recall, the
19 paediatricians wanted the police calling much sooner.
20 They wanted it, if you like, much earlier. From, from
21 my recollections, rather than doing those five or six
22 things that he talked about, when they first raised the
23 high mortality rates with Tony, I am assuming they
24 raised it, they wanted a police investigation at that
25 stage.

25

1 But from your call to Dr McGuigan, which we will come on
2 to, it doesn't sound like you thought the conflict had
3 resolved or that the paediatricians were going to get
4 what they wanted. So how do we reconcile the two?

5 **A.** Yes, not at that time.

6 And I think the relationships had been so damaged
7 during that process of time that, you know, Tony --
8 I remember Tony speaking to me in particular about
9 recovery of those relationships. He was, he was -- you
10 know, he was very upset that that had happened with the
11 relationships and even though I think they ended up
12 going down the right route, I think it was too late for
13 the relationships so to speak. That's my -- my view of
14 it, not that Tony or Michael said that to me.

15 **Q.** And if we just take stock at the moment that
16 call ended. Was it your understanding that Mr Chambers
17 was going to call the police after that call or that
18 there were going to be other steps that would be taken
19 which may mean the police weren't called?

20 **A.** I think that by the end of that call I can't
21 remember very clearly but I think that in Tony's mind he
22 was coming to the end of the road in terms of other
23 things and that the next step, and when that happened
24 after that call, I don't know, the next step would be
25 the police.

27

1 So not after they had done Royal College

2 investigations and other reviews.

3 I think that's where the conflict was. That's
4 where the tension was and I think they were getting
5 frustrated because they were waiting whilst all these
6 reviews happened and these reviews weren't giving them
7 the conclusions that they needed.

8 **Q.** But if the point had been reached, if it was
9 the point that Tony Chambers was saying to you: I am
10 going to call the police now, that firstly that conflict
11 is completely resolved?

12 **A.** Yes.

13 **Q.** Would you agree?

14 **A.** Yes.

15 **Q.** If that was his position and, secondly, the
16 Consultant paediatricians would be to some degree
17 vindicated because their point would have been what's
18 the point of doing all the other things?

19 **A.** Yes.

20 **Q.** We need to call the police and that is where
21 the situation has ended up?

22 **A.** Yes.

23 **Q.** So if that's right there doesn't seem to be
24 a problem any more for the Consultants, they have been
25 vindicated and they are about to get what they want.

26

1 **Q.** So your impression was that the police would
2 be called imminently after that call at the end of
3 March?

4 **A.** I wouldn't, he didn't give a timeframe. He
5 didn't give a view on that. It was just: we are nearing
6 the end of all of these things, there's one or two
7 things that just still need to conclude. And then, then
8 I think the last thing that we, we have to do is,
9 contact the police.

10 **Q.** But it sounds as if there are other things
11 that need to be resolved before the police are reached?

12 **A.** Yes.

13 **Q.** The conflict would in fact continue?

14 **A.** Yes, that, that was my view, is that there
15 were still things in train and that Tony Chambers wanted
16 to see those things conclude. I think I might have
17 written that in my statement he wanted to see things
18 conclude before he contacted the police.

19 **Q.** And does that mean, before we move on to
20 Dr McGuigan, that there was a possibility the police
21 wouldn't be called because the outcome of those
22 outstanding things would -- may mean that the police
23 weren't necessary?

24 **A.** Yes. If, if one of those reviews brought
25 a conclusion that satisfied everyone, including the

28

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

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

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

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

14 **A.** Yes.

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

17 **A.** Mmm.

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

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

29

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

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

6 **A.** Yes.

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

9 **A.** I think it was relatively soon.

10 **Q.** Same day?

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

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

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

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

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

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

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

11 **A.** Yes.

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

16 **A.** Yes.

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

18 **A.** Yes.

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

22 **A.** Yes.

23 **Q.** Did that cross your mind at all?

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

30

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

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

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

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

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

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

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

11 **A.** Yes.

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

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

20 Forgive me.

21 **A.** Yes.

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

33

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

3 **A.** Yes.

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

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

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

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

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

35

1 **A.** Yes.

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

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

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

19 **A.** That's correct, yes.

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

22 **A.** Yes, absolutely yes.

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

25 **A.** Yes.

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1 Consultants wanted a police investigation?

2 **A.** Yes, yes.

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

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

11 **A.** Yes.

12 **Q.** That paraphrase?

13 **A.** Yes.

14 **Q.** What about the rest of it?

15 **A.** Yes.

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

18 **A.** Yes. I don't recall that being said, that

19 I said that to Michael McGuigan, I don't recall Tony
20 saying that to me.

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

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

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

9 **A.** No.

10 **Q.** -- either of those?

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

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

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

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

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

3 **A.** Sorry?

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

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

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

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

22 **A.** Yes.

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

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

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

9 **A.** (Nods).

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

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

25 So that, that was the way the discussion went.

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

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

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

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

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

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

25 **A.** Yes.

40

1 Q. It is the second part I wanted to just cover
 2 with you. Next paragraph:
 3 "My other response was that I didn't feel I was
 4 working with a bunch of people who were ignorant and had
 5 got themselves on the wrong agenda but that I had a lot
 6 of confidence with the people I was working with."
 7 A. Yes.
 8 Q. "That this wasn't just the opinion of two
 9 people, but everyone was concerned in a similar way."
 10 A. Yes.
 11 Q. "I had confidence in my colleagues and they
 12 were trying to do right thing in a difficult situation."
 13 A. Yes.
 14 Q. Do you recall him saying that to you?
 15 A. Yes. Yes. And that was part of the
 16 discussion about, you know, where he said he had formed
 17 his views, he had been his own person, he had had a look
 18 at it, he had had discussions and that is the conclusion
 19 that he came up to.
 20 Q. We have covered what he recalls being said?
 21 A. Yes.
 22 Q. Obviously, sub text is also important, the
 23 implication of what is being said?
 24 A. Yes.
 25 Q. When you add up all the different things that

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1 You know, making sure that all avenues were explored,
 2 that, you know, that things, you know, it could be
 3 individuals, it could be people, it could be team
 4 working. We talked about team working and the impact on
 5 outcomes and that was much of the training that I used
 6 to give at Mid Cheshire especially with Consultants.
 7 I don't recognise it coming across as starkly as,
 8 as what Michael has written in the statement there.
 9 Q. Well, if we just put together some of the
 10 things that you recall.
 11 A. Yes.
 12 Q. Starting the conversation by saying you have
 13 known Tony Chambers for a long time might tend to
 14 suggest that you admired, respected him, liked him, had
 15 no reason to think that he would be wrong about it and
 16 of course he is on the opposite side of the dispute?
 17 A. Yes.
 18 Q. So might that give the impression that you are
 19 here acting on Tony's behalf or trying to support him in
 20 the dispute?
 21 A. I actually I believe started the discussion by
 22 saying: this is a phone call that I asked Tony if
 23 I could make. I am not ringing because of him. So I do
 24 recall being very clear about that. This was, this is
 25 about seeing how you are, Michael.

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1 everybody chooses to talk about?
 2 A. Yes.
 3 Q. This is what he says about the implication.
 4 Next paragraph:
 5 "The implication of what she was saying is that the
 6 paediatricians should be recognising the faults within
 7 themselves and their department and addressing them and
 8 that because they are egotistical, selfish or in denial
 9 this they were trying to push the problem on to someone
 10 else, that they are bad people who are heading for
 11 a downfall."
 12 So that is not him saying you said any of those
 13 things, so we will be clear about that?
 14 A. No.
 15 Q. As is obvious from the fact that he says "the
 16 implication" but that is what he is saying he took away
 17 from what you said?
 18 A. Yes.
 19 Q. Do you think that is a reasonable implication
 20 for him to draw?
 21 A. I don't recall really recognise much of that,
 22 in all honesty. And, you know, I have tried to think
 23 about how he might have formed those impressions and
 24 I think that may have been the discussion about
 25 exploring all avenues, that is all I can put it down to.

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1 In some respects I was being a little bit nosy.
 2 Tony had given me a version of events and in some
 3 respects I was trying to know more from Michael, see if
 4 there was anything different there. I didn't
 5 particularly get that. And I think Michael knows --
 6 I think knew me well enough to know that I wouldn't be
 7 making that kind of discussion, whilst I did respect
 8 Tony or do respect Tony, and, you know, I have known him
 9 a long time, I also respect Michael and respect very
 10 much Michael's views.
 11 Q. If we just pick out another thing. You
 12 revealed to him that you knew that there were two people
 13 leading the charge?
 14 A. I did.
 15 Q. Which might be thought by some as Mr Chambers
 16 having revealed quite a lot about the dynamics of the
 17 dispute and the fact that they were two people who he
 18 had identified as being particularly responsible for the
 19 conflict?
 20 A. Yes.
 21 Q. So again do you recognise that that might
 22 cause a person hearing that to think: gosh, Mr Chambers
 23 is talking to his friends about two particular doctors
 24 who are causing the problem?
 25 A. Yes, absolutely. And -- and he was very clear

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1 to me it wasn't just the two.

2 **Q.** Well, that was his perspective?

3 **A.** Yes.

4 **Q.** But that is what he was --

5 **A.** Yes.

6 **Q.** He understood that Mr Chambers ... and by
7 telling him to "be his own man" again this is your
8 recollection, do you see that a person might take from
9 that that what you are saying is: you have made the
10 wrongdoings, I am worried you are being a sheep, you
11 need to be more objective?

12 **A.** I don't think Michael saw it as that. It
13 was -- it wasn't that kind of discussion, it was a very
14 friendly discussion, it was quite light and it was just
15 you know, just please be your own person and we just had
16 a discussion around the events and it didn't, it wasn't
17 like that you know, and he was quite content with where
18 he had got to in terms of his thinking.

19 He didn't feel, you know, under pressure from that
20 end, from the Countess of Chester end. He felt he had
21 made his own decision on things and where things were up
22 to.

23 **Q.** Well, he's described the implication. You are
24 right to draw attention to how he concluded the
25 conversation?

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1 did you then call Tony Chambers to say: I have spoken to
2 Dr McGuigan, he absolutely isn't being a sheep here.
3 He's got good judgement. You must call the police?

4 **A.** I didn't. I didn't ring him back after the
5 call but I know I will have spoken to Tony about it
6 perhaps when I saw him at a meeting and that meeting
7 likely happened soon after, you know, I wouldn't have
8 let that drift on. Yes.

9 **Q.** But bearing in mind that this was a patient
10 safety issue --

11 **A.** Yes.

12 **Q.** -- do you think you should have called
13 Mr Chambers back immediately to say: look, I can give
14 you a particular insight into Dr McGuigan that you just
15 don't have. He believes it. He's not being a sheep.
16 You need to call the police immediately. Do you think
17 that's something you should have done?

18 **A.** On reflection, you can say yes, possibly it is
19 something that I should have done. But in my mind at
20 that time, Tony was going to call the police. She
21 wasn't -- Lucy Letby wasn't working in a clinical
22 environment at that time so in terms of immediate safety
23 concerns, there weren't any.

24 **Q.** Did you know anything about the discussions
25 about returning her to work?

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1 **A.** Yes.

2 **Q.** We will just read it into the record there:

3 "I did not feel any pressure from that phone call
4 or that she was calling me to tell me to shut up. It
5 was purely that she was concerned that I was in a tricky
6 position, wondering if I was making the wrong judgment
7 calls and warning me about how it might be seen by other
8 people. It was purely a friendly call to tell me to be
9 careful about the situation."

10 **A.** Yes.

11 **Q.** I think you say in your witness statement that
12 while you don't recognise the implication that he has
13 recorded --

14 **A.** Yes.

15 **Q.** -- that he reached, that that is your
16 perception of the call?

17 **A.** Yes, pretty much, yes.

18 **Q.** Now, having had this call with Dr McGuigan and
19 he having been, if this is fair, adamant that he has
20 chosen the right side of this conflict, that he believes
21 in his colleagues, that it isn't a question of one group
22 being led by two charismatic figures but this is a body
23 of opinion, bearing in mind you knew that the body of
24 opinion was: the police need to be called immediately
25 because we are worried an individual is killing babies,

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1 **A.** No.

2 **Q.** And do you think that's something you should
3 have been told if there were discussions about returning
4 her to work at the time you spoke to Mr Chambers?

5 **A.** Tony would have no reason to tell me that kind
6 of thing at all apart from seeking advice. In my mind,
7 that is the kind of discussion that I would likely have
8 with a Chief Nurse, maybe even NHS England, maybe even
9 CQC. That -- Tony had no obligation to tell me about
10 that.

11 **Q.** No, but it seems he did tell you that she
12 wasn't working?

13 **A.** Yes.

14 **Q.** And so that's one piece of the puzzle?

15 **A.** Yes.

16 **Q.** But if it's also the case she's not working
17 but there is a plan to return her to work, if that's the
18 case, would you have expected him to tell you that
19 second piece of information because otherwise the first
20 piece of information may be thought to be misleading?

21 **A.** Yes, yes, unless he didn't know at that time
22 and I don't know.

23 **Q.** No, well whether or not, but I am asking in
24 the hypothetical, that if that was the plan as at the
25 time of your conversation --

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

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1 I may to ask you a very few questions about your own CV.
 2 A. Sure.
 3 LADY JUSTICE THIRLWALL: So you started off
 4 training as a nurse in 1984 at the Royal Bolton
 5 Hospital?
 6 A. Yes.
 7 LADY JUSTICE THIRLWALL: I can't quite remember,
 8 was that before there was a requirement that nurses had
 9 to have a degree?
 10 A. Yes, it was.
 11 LADY JUSTICE THIRLWALL: So this was the --
 12 A. Yes.
 13 LADY JUSTICE THIRLWALL: -- old style nursing
 14 training.
 15 A. It was old style, you were employed by the
 16 hospital and trained by the hospital where you would
 17 then subsequently work. Project 2000 --
 18 LADY JUSTICE THIRLWALL: That is what it was.
 19 A. -- was where it then became a degree
 20 profession and you were trained by universities.
 21 LADY JUSTICE THIRLWALL: Yes, thank you. So as you
 22 tell us I think you worked as a nurse in various roles
 23 until December 1999. I am assuming from that that
 24 although you had management roles, you were still
 25 working clinically as a nurse as well?

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1 him. It, it wasn't specific discussions or phone calls
 2 specifically and only about that.
 3 It would have been, you know, conversations in
 4 passing where we would talk about numerous things and
 5 I would have said: how are things going? But I would
 6 have also updated him about the phone call with
 7 Michael McGuigan.
 8 Q. And what did you tell him?
 9 A. My recollection would be that Michael feels
 10 comfortable with where he's at, feels that the
 11 Consultants are, are right and he feels safe and, and
 12 I think that's probably as much as I would have said.
 13 MR DE LA POER: Ms Bullock, thank you very much
 14 indeed for answering my questions.
 15 My Lady, there are no questions from
 16 Core Participants.
 17 Questions by LADY JUSTICE THIRLWALL
 18 LADY JUSTICE THIRLWALL: Thank you, Mr De La Poer.
 19 Thank you, Ms Bullock.
 20 There are just a couple of questions not about your
 21 conversations with Tony Chambers but we have been
 22 hearing in recent days about the development of managers
 23 within the NHS?
 24 A. Yes.
 25 LADY JUSTICE THIRLWALL: And I just would like if

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

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1 intelligence that I got.

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

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

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

21 **A.** That was ...

22 **LADY JUSTICE THIRLWALL:** Just roughly?

23 **A.** Roughly I would say early '90s.

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

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

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

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

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

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

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

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1 role?

2 **A.** Yes, yes.

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

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

7 **LADY JUSTICE THIRLWALL:** It was a night school
8 thing.

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

11 **A.** No.

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

14 **A.** No, it was in my own time.

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

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

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

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

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

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

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

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

23 **A.** Yes.

24 **LADY JUSTICE THIRLWALL:** -- from something like
25 that --

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1 A. Yes.

2 **LADY JUSTICE THIRLWALL:** -- which some people may

3 be better at than others?

4 A. Yes.

5 **LADY JUSTICE THIRLWALL:** But again was that

6 something that was already in place or did you ask for

7 it and it was given to you as a matter of course?

8 A. I asked for it --

9 **LADY JUSTICE THIRLWALL:** You asked for it.

10 A. -- and sourced that myself as well. Yes.

11 **LADY JUSTICE THIRLWALL:** Presumably it was paid for

12 by the organisation?

13 A. Yes, yes. I would say all of my coaching was

14 paid from by the organisation.

15 You know, some might see coaching as pink and

16 fluffy. I would see it as pretty critical to evaluate

17 your thinking, yes.

18 **LADY JUSTICE THIRLWALL:** Yes. Thank you very much

19 indeed, Ms Bullock. Does anybody else want to ask any

20 questions arising out of that or anything else? No.

21 Thank you very much indeed for your evidence. You

22 are free to go.

23 A. Thank you.

24 **LADY JUSTICE THIRLWALL:** Mr De La Poer, I think it

25 is convenient to take the break now.

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1 A. It is.

2 **Q.** Are you the Professor of Health Policy and

3 Management at the Health Services Management Centre in

4 the School of Social Policy and Society at the

5 University of Birmingham?

6 A. I am.

7 **Q.** And have you held that post since 2015?

8 A. Yes.

9 **Q.** I am just going to briefly review how you

10 reached that point which you deal with in a little more

11 detail at the start of your second statement. Have you

12 worked in health services, research, evaluation and

13 development since 1995?

14 A. Yes.

15 **Q.** And prior to that, were you a senior manager

16 in the NHS?

17 A. Yes.

18 **Q.** And did you reach that position having

19 undertaken the NHS graduate management training scheme?

20 A. I did.

21 **Q.** And just to help us when you say "senior

22 manager", what sort of role, description did you hold?

23 A. I was a general manager of effectively

24 a division within a hospital, a period of that time it

25 was for Women's and Children's services, that was the

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1 **MR DE LA POER:** Yes, please.

2 **LADY JUSTICE THIRLWALL:** And we will start again at

3 11 o'clock.

4 **(10.42 am)**

5 **(A short break)**

6 **(11.00 am)**

7 **LADY JUSTICE THIRLWALL:** Mr De La Poer. We have

8 got Dr ...

9 **MR DE LA POER:** Professor Smith is with us.

10 **LADY JUSTICE THIRLWALL:** I beg your pardon,

11 Professor Smith, do remain seated while you take the

12 oath.

13 **PROFESSOR JUDITH SMITH (sworn)**

14 **Questions by MR DE LA POER**

15 **LADY JUSTICE THIRLWALL:** Yes.

16 **MR DE LA POER:** Please could you give us your full

17 name.

18 A. Judith Ann ^ Smith.

19 **Q.** And, Professor Smith, is it right that you

20 have provided to the Inquiry two witness statements, one

21 dated 7 June of last year, the other 3 January of this

22 year?

23 A. That is correct, yes.

24 **Q.** Is the content of those statements true to the

25 best of your knowledge and belief?

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1 last role I held in the health service.

2 **Q.** In terms of your teaching and research and its

3 focus, is it on the organisation and management of

4 primary and integrated care, evaluation of new models of

5 care, healthcare management and organisational

6 governance?

7 A. Yes.

8 **Q.** And are you one of the authors of the main

9 international textbook on health management?

10 A. Yes.

11 **Q.** And no doubt there are very many other

12 academic publications for practitioners, policy and

13 academics?

14 A. Yes.

15 **Q.** Between 2015 and 2022, were you the director

16 of HSMC and a member of the university's leadership

17 forum?

18 A. Yes.

19 **Q.** And you have also had a period as the Director

20 of Policy at the Nuffield Trust and been employed at the

21 University of Birmingham as a Fellow and then senior

22 lecturer and you have also been a researcher undertaking

23 a fellowship at the Health Services Research Centre in

24 New Zealand, and advised the New Zealand Ministry of

25 Health on policy?

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1 A. Yes.

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

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

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

17 A. Yes.

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

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

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1 income part of the world.

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

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

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

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

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

10 A. Yes, I have.

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

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

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

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

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

13 Q. What you say is that:

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

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

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

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

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

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

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

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1 class managers are to be attracted?

2 **A.** I think many of the managers and senior
 3 managers in the NHS are world class. I think there are
 4 absolutely excellent people doing very difficult jobs
 5 enabling us as a population to have some really world
 6 leading healthcare.
 7 However, that's not always the case. But in terms
 8 of what attracting other people to NHS management,
 9 I think -- I mean, sometimes a critique has been made
 10 that NHS management can be because the NHS is so large
 11 it's almost like a it's own world and it's not always
 12 been easy for people who have come into NHS management
 13 perhaps from local government or the private sector or
 14 the voluntary sector, so I think when we consider both
 15 how NHS management could be further professionalised but
 16 thinking about its training and development I think
 17 always making sure there are opportunities for
 18 programmes that are not just about developing the people
 19 who happen to be already in or inside, but that are
 20 explicitly open to others with experience from other
 21 sectors. That has been tried at different points in the
 22 past with some success but I think trying to keep that
 23 openness and wider vision is important for a service
 24 that's as large as the NHS.

25 **Q.** Now you deal with the concept of hybrid

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23 **A.** Yes.

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

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

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

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

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

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

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

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

13 **Q.** You have The Lord Darzi?

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

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

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

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

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

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

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

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

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

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

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

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

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

9 **A.** I really like the code and it's why I set it
10 out in my statement in the way I do and I remember back
11 in 2001/2 being really encouraged by the fact that the
12 move was being made to develop the Code of Conduct and
13 I also like -- I like the fact it's concise and I like
14 the personal nature of the statements. They feel to me
15 very clear and looking at them now, what it's almost
16 25 years later, they still feel to me very real and
17 relevant.

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

25 What's your understanding and perception about why,

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

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

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

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

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

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

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

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

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

7 **A.** Yes.

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

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

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

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

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

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

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

19 **A.** Yes.

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

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

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

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1 what he was driving at.

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

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

12 Do you have a view about that?

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

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

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1 apply that behaviour and indeed then you can train
2 against those, those standards.
3 I'm not quite sure that the competent -- the recent
4 competency framework for me quite gets there and my
5 other concern about that based on my experience working
6 alongside the NHS and in it would be that: what does
7 that replace? Where does that leave the -- I think it
8 was called the Healthcare Leadership Model from about

9 10 years ago, where does that now go?
10 But how long will this one last for? It's this
11 issue of how new documents or guidance as I said earlier
12 come out but it's not clear what is then retired which
13 is the one that's then the current one and how is it
14 actually to be applied in practice.

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

20 **A.** Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 **A.** Either of those are Royal College.

22 **Q.** The Royal College?

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

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1 of Health Leaders, that is the sort of thing. Or
 2 I guess there is some similarity to the Faculty of
 3 Medical Leadership and Management.
 4 **Q.** So just one aspect I want to ask you about
 5 there, this idea of a register and how that might work
 6 practically. In the statutory model the register is
 7 maintained by the statutory regulator, the statutory
 8 regulator has a statutory structure for determining who
 9 gets on the register and it has a statutory structure
 10 for ensuring that people who transgress are removed from
 11 it.

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

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

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

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

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

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

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

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1 that.

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

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

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

25 **Q.** You have mentioned the consultation, that was

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

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

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

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

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

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1 how this should be, that will be really important.

2 But for me as a minimum I think it will need to
3 include a professional register and I say whether
4 voluntary or compulsory, I am open about that, and as
5 I have indicated earlier, I feel that even a voluntary
6 one would probably be in effect could be considered
7 compulsory. But then a Code of Conduct, a requirement
8 for Continuing Professional Development and the use of
9 the Fit and Proper Persons Test.

10 **Q.** Now, one of the comments that you make in your
11 second witness statement about the code is you identify
12 as we have already covered the 2002 code. You also draw
13 attention to the Nolan Principles of public life and
14 a third Professor Don Berwick's principles for leading
15 a high quality and safety healthcare system and we
16 haven't talked about those yet.

17 If you want to have them in front of you they
18 appear at 47 on page 17 of your first witness statement
19 and I wonder if it's worth, if you don't mind, just
20 reading out what Professor Berwick suggested and what
21 your view is about the way he's formulated it?

22 **A.** Yes, I mean, my reason for mentioning that
23 was -- I mean, because I have talked about the Code of
24 Conduct already, the Nolan Principles are well known and
25 I know actually they are connected in with the

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1 transparency about the patient voice and the primacy of
2 quality and safety.

3 **Q.** Now, just one final matter on the consultation
4 which is a comment that you make and I'm sorry to have
5 moved you between your two statements. You say this at
6 paragraph 13(vii) on page 5 about investment in training
7 and development; so in other words not just what does
8 the system look like, but how do we get people to
9 operate well within the system?

10 So can you just please amplify why you have drawn
11 attention to that particular feature and the degree to
12 which you think it's important?

13 **A.** I have drawn attention to it because it's also
14 highlighted by many others such as Sir Stuart Rose in
15 his review of NHS leadership and by Sir Gordon Messenger
16 and Dame Linda Pollard in their review a couple of years
17 ago and I think when people undertake those sort of
18 reviews it's a frequent finding they are quite surprised
19 that for a service of such an extent and so many
20 employees that the managers and leaders are not actually
21 formally required to undertake particular training and
22 development but also how patchy it can be, the
23 resourcing and provision of that for them.

24 And actually in my first statement I reference work
25 by the Health Foundation -- esteemed Research Foundation

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1 leadership competencies that NHS England have recently
2 issued.

3 Professor Don Berwick is a recognised international
4 expert on patient safety and care quality and he was
5 brought in by the UK Government in the wake of the
6 Francis Inquiry to help, review and advise about patient
7 safety so that's when he -- when he issued what's
8 actually it's a -- his document was called "A promise to
9 learn -- a commitment to act". It's a commendably short
10 document.

11 The principles he talks about in there are placing
12 the quality of patient care, especially patient safety,
13 above all other aims. Then engage, empower and hear
14 patients and carers throughout the entire system and at
15 all times. Then foster wholeheartedly the growth and
16 development of all staff, including their ability and
17 support to improve the processes in which they work.
18 And, finally, embrace transparency unequivocally and
19 everywhere in the service of accountability, trust and
20 growth of knowledge.

21 I think I have, I have included those because again
22 I think they are concise. They feel to me again they
23 are quite enduring and they pick up a number of the
24 themes that I know you have discussed with Sir Robert
25 Francis and Professor Mary Dixon-Woods as well about

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1 in London, who did work looking at NHS management,
2 I think it was in 2022, and again particularly
3 highlighted the fact that people again, particularly
4 clinicians moving into management, many of the ones
5 they, they surveyed and worked with in that study hadn't
6 had any training and development for the role.

7 So I am, I just really want to emphasise that point
8 that I feel that professionalising and regulating
9 management I feel the time is right for that, but I also
10 feel the time is right to really support, resource and
11 put in place more systematic and more available training
12 and development for people and particularly at those
13 key, key points of transition.

14 So starting in your management role often if you
15 are in a mid-management role and I think another
16 critical one is when you are moving to board level as an
17 Executive, I think that's another one.

18 **Q.** Thank you. So we will go back to your first
19 statement, please, and we have dealt with many of these
20 topics before but under your third heading "Leadership
21 qualities and behaviours for senior NHS managers", you
22 begin that section by talking about the consequences of
23 uncompassionate healthcare leadership.

24 I just would like you, please, to speak to the
25 topic of uncompassionate healthcare leadership and the

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1 degree to which you think it is a problem in the NHS in
2 2024?

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

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

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

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

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

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

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

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

15 **A.** Mmm.

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

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

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

5 You identify a number of bodies in the course of
6 your statement and I would just like you to just explain
7 who they are, what they do and are they effective. So
8 we begin with the NHS Leadership Academy established in
9 2012 and where we are with that.

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

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

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

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

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

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

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

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

9 **A.** That's correct, yes.

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

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

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

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

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

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

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

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

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

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

25 **A.** I think that is absolutely critical to

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4 **A.** Yes.

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

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

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

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

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

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1 individuals often joining at a time.

2 And that is the significant availability of that
3 particularly through NHS providers, some of that is in
4 person again now. Of course it all used to be and of
5 course I personally think there is some downsides to
6 more of it having become online and I think it's also
7 something that could and should be picked up in
8 appraisals of Non-Executive Directors and I think it is
9 in some cases.

10 But it's this in some cases and variability point
11 that --

12 **LADY JUSTICE THIRLWALL:** Of course by the time you
13 are appraising people, then they have been in post for
14 a while?

15 **A.** Exactly. I think it is reasonable to have
16 an expectation you will do a certain core of briefing
17 and training when you join.

18 **LADY JUSTICE THIRLWALL:** Yes, thank you, sorry,
19 Mr De La Poer.

20 **MR DE LA POER:** Not at all, my Lady.

21 Topic five is the one that you said that you were
22 expecting we would come back to, you are quite right,
23 the role of NHS boards in quality and safety governance.

24 I just want to go to some parts of this but I did
25 want to give you the opportunity because you indicated

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1 patients and staff or assure the correction of
2 deficiencies brought to the Trust's attention.

3 And I note that in the Care Quality Commission they
4 have what's called the well-led framework which I am
5 sure you have probably discussed already, forms part of
6 the assessment of NHS Trusts when the Care Quality is
7 reviewing them and their guidance about the well-led
8 framework again makes it clear that the buck stops with
9 the board of a Trust in terms of quality and safety.

10 **Q.** So one of the matters you draw attention to --
11 here I am looking at paragraph 84 on page 30 of your
12 witness statement -- is the idea I think which was first
13 mooted by Professor Sir Nick Black about a Chief Quality
14 Officer role and I would just like you to explain what
15 you understand that that might be, why that might be
16 a good thing and whether there is a risk that a board is
17 going to become too top-heavy, too complicated, there
18 are too many board members with particular interests so
19 just incorporating all of those aspects please tell us
20 about a Chief Quality Officer role?

21 **A.** Professor Sir Nick Black who -- he's
22 a renowned international expert on health research,
23 particularly clinical audit and he is a clinician by
24 background, he -- he was brought in to work with
25 Professor Sir Bruce Keogh after the Francis Inquiry

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1 earlier that you regard this as being absolutely central
2 to the whole structure of how things can be improved and
3 kept safe.

4 So can you just speak to that, please, for a moment
5 or two, just why is it so important that the NHS board
6 acts in such a way as to ensure good governance?

7 **A.** Well, I think that two points, the first is
8 one I made earlier about the fact that an NHS board has
9 got this dual responsibility for patients' care and
10 safety on the one hand and financial and resource
11 management on the other, you know, they are its two
12 formal duties.

13 My other one would be is that we know from
14 Inquiries, and particularly I would highlight here the
15 Mid Staffordshire Inquiry that was undertaken by
16 Sir Robert Francis, and actually Liverpool Community
17 Health which was that Inquiry was undertaken by
18 Dr Bill Kirkup because in both those cases, they pointed
19 to the failure of the board and its failure to govern
20 and assure patient safety and quality as a central point
21 and in fact Robert Francis on the day he launched his
22 Inquiry report in 2013, I mean he -- I quote here and it
23 is in my statement but he said: this was primarily
24 caused by a serious failure on the part of a provider
25 Trust board, it did not listen sufficiently to its

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1 looking at quality and safety in the NHS. They
2 particularly spent time actually looking at Trusts that
3 were considered to be particularly struggling or
4 failing.

5 But it was around that time that he, he wrote and
6 talked about this idea of the Chief Quality Officer and
7 I think it's a role that has been used more in the
8 United States. I just mentioned it. I am not
9 advocating that every board should have one. But
10 there's something about what he says here about having
11 making sure that someone on the board has got the
12 technical and scientific expertise about all the domains
13 of quality about effectiveness safety patient experience
14 and so on, and also the understanding of the -- he talks
15 about the behavioural organisation barriers to making
16 change.

17 I think what this raises for me and why I included
18 it in my statement is it's for a board when thinking
19 about, or I guess a chair but with the board members,
20 thinking about the skills they have got around the board
21 table to be sure they have got those sort of skills.

22 Now, maybe it might be the Medical Director has got
23 those or the nurse director; they tend to be the
24 colleagues who do have the kind of lead for quality at
25 the board table. But I think his challenge is, I just

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

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

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

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

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

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

23 Why I think it's critical is it's where clinical
24 governance comes together really with corporate
25 governance. It's where -- I mean clinical governance
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1 at least one of those Non-Executive Directors should be
2 a clinician by background so to help them under --
3 because they are likely to more better understand some
4 of the intricacies of the of the data and the issues.
5 But it's at the Quality Committee where you will be
6 reviewing data.

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

20 But it's -- my experience was it's where you get
21 really the more in-depth insights into what's happening.
22 You work closely with particularly the Medical Director
23 and the nurse director but also colleagues would be
24 brought in sometimes to present and discuss issues
25 happening in their area and that might be because they'd
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1 happens throughout the organisation where staff are
2 looking at data about quality and safety, working out
3 patterns, working out if actions need to be taken, if
4 there are problems. But that all really comes together
5 in -- the Quality Committee is where there's that board
6 oversight of quality and safety for that duty of the
7 board for quality and safety, just as you'd expect in
8 the finance committee the same is happening for that,
9 that other duty.

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

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

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

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

25 There's also increasingly discussion about the fact
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1 got problems or because they'd got new developments that
2 you wanted to understand that were going to be properly
3 clinically governed, so ...

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

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

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

22 **A.** No. That, that to me is large and from my
23 experience and my reading of guidance from people like
24 NHS Providers, I'd would normally expect as I indicated
25 I think in my remarks just now three, possibly four
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1 Non-Executive Directors at most, probably three, then
2 chief Medical Officer, a chief nursing officer.
3 Often actually you might have the director of
4 workforce or human resource management if you are
5 considering workforce issues in the Quality Committee
6 that you often do. They probably would be actually the
7 main members of the committee. There may be one or two
8 others in attendance. Perhaps there's a nurse or
9 medical lead for sort of clinical governance who works
10 to the chief Medical Officer or chief nursing officer.

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

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

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

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

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

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

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

22 **LADY JUSTICE THIRLWALL:** Yes.

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

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

3 **LADY JUSTICE THIRLWALL:** Yes, thank you.

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

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

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

15 **A.** When I was a Non-Executive director?

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

18 **A.** Yes.

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

21 **A.** Oh, absolutely.

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

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

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

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

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

15 **A.** Yes.

16 **LADY JUSTICE THIRLWALL:** -- of change?

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

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

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

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

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

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

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

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

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

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

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

18 **A.** Not at all.

19 **LADY JUSTICE THIRLWALL:** Would that be all right?

20 **A.** I am in your hands.

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

23 (12.30 pm)

24 (The luncheon adjournment)

25 (1.30 pm)

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1 to challenge and so forth.

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

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

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

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

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1 **LADY JUSTICE THIRLWALL:** Yes.

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

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

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

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

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

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

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

7 **A.** Yes.

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

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

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

25 "They appear too often unable to be self-critical
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1 positions in for example NHS England because they are
2 subject to political central pressures sometimes that
3 may be -- may be affecting those behaviours that can
4 sometimes be problematic for those on the receiving end
5 of them.

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

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

17 **A.** Yes, and it's -- this is a concern that's been
18 raised over -- over the years and it's behind or for me
19 in some of my suggestions in my conclusions in the
20 statement about what might be able to help resolve some
21 of that or shift that culture, you know, include my
22 point about that the -- any move towards regulation of
23 managers should include the senior managers within, for
24 example, NHS England and also that it feels appropriate
25 to me that the duty of candour should apply to
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1 or demonstrate sustained learning in respect of its
2 behaviour towards those NHS leaders looking to it for
3 guidance, support and direction."

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

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

16 And I am drawing there on, as I said earlier, on
17 reports and work that's been done on that both in
18 Inquiries but in other contexts, such as the work we
19 mentioned earlier for NHS Confederation or Sir Ron Kerr
20 in his report about Executive leadership. So there's
21 something about the stated behaviours and approaches not
22 always perhaps being lived out in practice and my sense
23 would be and from reading those reports and what we have
24 heard about it from other Inquiries is that sometimes
25 that those individuals themselves are in difficult
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1 individual managers and Non-Executives and Chief
2 Executives but again to those individuals, so that for
3 example in NHS England or the Care Quality Commission
4 that those managers and leaders are being treated as
5 part of that same management community and may in its
6 own way assist them because I think they have their own
7 dilemmas that they are having to handle sometimes in
8 terms of behaviours and priorities.

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

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

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

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

2 I know -- I know you have heard evidence on that
3 particularly from Sir Robert Francis and I think that
4 continues to be a work in progress and I think it is
5 progressing.

6 And even in my own time as a Non-Executive Director
7 I saw that taking shape and starting to have an effect
8 so I think that is important.

9 It's -- cultural change is difficult but I think
10 having the guardians as people who staff can go to,
11 obviously they need to know that, but as a route for
12 speaking up it's really important. But the reason why
13 I talked about this needs to have now as well focus on
14 the listening and responding, is partly because that's
15 what evaluation and study of the Freedom to Speak Up
16 Guardians is telling us because I think it is one thing
17 to speak up but to start to understand how -- what it
18 looks like where there's a good response, a positive
19 response, and I think this is where evaluation and
20 research can help, what does it look like in a Trust
21 where they are able to -- consistently, one hopes --
22 respond to episodes of speaking up and why is it they
23 can do that and perhaps other places it doesn't happen?

24 And I think then to understand try and understand
25 what is it that can help managers and leaders listen,

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1 your insights into it. I mean, first and foremost, do
2 you agree with the analysis and conclusions of that
3 report? Do you think they have got it right when they
4 say there is a problem, and this is why there's
5 a problem?

6 **A.** I do. And I also think the report is helpful
7 in that it's -- it's had a look at -- well, it's looked
8 both across Inquiries in this country and looked at some
9 international experience but I think it's really helpful
10 that it starts to set out some possible solutions or
11 things to try that, and I do say in my statement some of
12 the ones I think are particularly I think have some
13 potential, so no, I think it's a very useful report.

14 **Q.** You draw out at paragraph 24 the suggestion
15 that a Joint Select Committee is used to monitor the
16 recommendations of the Inquiries. Is that the
17 suggestions they make one that you promote and say you
18 think is a good solution to the problem?

19 **A.** Yes, I think I say in my statement that I
20 think that would be a Joint Select Committee of the
21 Houses of Commons and Lords that would have
22 a responsibility for, yes, monitoring and following up
23 routinely on the recommendations or certainly those
24 recommendations that have been accepted by Government to
25 follow up how well they are implemented or not.

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1 hear, make those responses and some of this may well
2 connect across to what we have talked about earlier
3 about regulation and indeed training for people as well
4 because it's quite difficult work to do.

5 So I think that that's why I was thinking about
6 it's more it is part of, this is now a few years in,
7 I think people are giving attention to that other
8 important part of that, that process.

9 **Q.** Your final topic is headed "Reasons why
10 Inquiry recommendations don't work" and you deal in your
11 first statement with that topic but you are able to
12 bring it up to date in a way and draw together the
13 various themes in your second statement and I wonder if
14 I can just invite you to turn that up so you have that
15 to hand, it starts on page 7, paragraph 20.

16 Here you refer to the House of Lords Statutory
17 Inquiries Committee publishing its report in the early
18 autumn of last year and the observation made in the
19 report is too often Inquiries are failing to meet their
20 aims because Inquiry recommendations are not
21 subsequently implemented, despite being accepted by the
22 Government.

23 And obviously that report goes into a great deal of
24 detail and people can read it for themselves; it is
25 publicly available. We have you here, however, to get

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1 I also suggest alongside that that it was one point
2 in this report that -- I mean, I hadn't known about this
3 until I read this report, but it talks about an approach
4 used in Australia of an independent implementation
5 monitor, a person who is appointed at the point at which
6 an Inquiry report is published, a person of significant
7 standing who will in one sense I guess almost have an
8 individual role certainly for a number of months in sort
9 of tracking what's happening about recommendations and
10 whether on the ground or things are really happening as
11 they are being told in policy terms.

12 So I just thought that was an interesting one to --
13 that might be considered alongside it. But it was based
14 on what I had read in the House of Lords report.

15 **Q.** The end of the process is monitoring what
16 recommendations that have been made. The start of that
17 process is the making of the recommendations. I think
18 you make some observations at your paragraph 29 drawing
19 out from your first report and I think entirely
20 consistent with what the House of Lords was saying in
21 this regard; that it's extremely important that the
22 recommendations which are developed are ones which can
23 be and are capable of being implemented.

24 And so I wonder if you could just identify one or
25 two that you think are most important when it comes to

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1 how a recommendation should be formulated?

2 **A.** Yes, and I was very much in my thinking here,
3 a colleague of mine at the University of Birmingham,
4 Professor Martin Powell, has done work looking at --
5 looking back at Inquiry recommendations and trying to
6 understand why they are implemented or not and he has
7 this term "implementable". But I think it's
8 an important term.

9 So I then here, as you have just said, I have drawn
10 from my first statement when I was preparing this one
11 much more recently just to, yes, suggest a few
12 recommendations that are implicit in my statement that
13 feel like they might be implementable, so I will suggest
14 just a few of them here.

15 I mean one, to pick up on the point we were talking
16 about just before lunch is to mandate the fact that
17 there should be a Quality Committee in every Trust and
18 to say something about the sort of membership it should
19 have and ideas about the sort of Terms of Reference and
20 remit. That feels to me like one -- it feels to me it's
21 inappropriate that there isn't a mandate to have
22 a Quality and Safety Committee in an NHS Trust, so
23 that's one I have got.

24 Also to establish a Code of Conduct for NHS
25 managers with underpinning set of standards embedded in
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1 much indeed. I am conscious I have been highly
2 selective in asking you questions in relation to well
3 over 50 pages of careful and detailed report from you.

4 I just want to check with you before I turn over to
5 Mr Baker, who has some questions for you, whether I have
6 omitted any matter which you have not spoken about that
7 you consider it's important that the Inquiry hears
8 directly from you as you sit there?

9 **A.** No, I think my overriding points are about the
10 critical importance of clinical governance about how
11 that intersects and is part of what the board, the Chair
12 and Chief Executive do and it is -- that it is time to
13 professionalise and regulate NHS management, that that
14 will happen within the complex and sometimes problematic
15 wider culture of the NHS and that there are things that
16 can be done to ensure that Inquiry recommendations that
17 more of them are implemented. Many are, but a lot more
18 could be. So I think that, yes.

19 **MR DE LA POER:** Thank you very much indeed,
20 Professor Smith.

21 My Lady those are the questions that I have.
22 Mr Baker has permission for some questions.

23 **LADY JUSTICE THIRLWALL:** Very good. Mr Baker.
24 Questions by MR BAKER

25 **MR BAKER:** Good afternoon, Professor, I ask
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1 employment contracts and with some system of formal
2 regulation of managers.

3 And also that another one that that Code of Conduct
4 standards and regulation, as I have said before, should
5 apply to managers within NHS England and other
6 arm's-length bodies as well as Trusts and Integrated
7 Care Boards.

8 And another one, and perhaps while I think I have
9 talked about it already and understand that I feel quite
10 strongly about this is that any approach to regulation
11 and professionalisation for me must include a real focus
12 on training and development and the proper provision of
13 that but also expectation of that, so that those for me
14 are two sides of the same coin.

15 And I guess my -- the final two perhaps that are
16 there on the list, one was about: could the NHS
17 Appointments Commission be re-established? I think
18 it -- it worked well to oversee recruitment, training
19 and development appraisal of Non-Executive Directors and
20 Chairs.

21 And finally, to link together what we are just
22 talking about, that there be some sort of formal process
23 for monitoring the implementation of Inquiry
24 recommendations that are accepted by Government.

25 **MR DE LA POER:** Professor Smith, thank you very
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1 questions on behalf of two of the Family groups.

2 You will have seen from the summary that I have
3 permission to ask questions over a very broad range of
4 topics and 10 minutes to ask them. Rather than doing
5 that I am going to focus in on one aspect and that's in
6 relation to uncompassionate healthcare, so if we could
7 look, please, to paragraph 40 of your witness statement.
8 In particular the table that's under it and the table
9 comes from the King's Fund Library Service and describes
10 in a nutshell issues with uncompassionate healthcare and
11 the first paragraph talks about and leads to a focus on
12 chasing targets and a culture of fear and blame.

13 I think that picks up on something you said towards
14 the end of your evidence as well about targets and fear
15 of targets?

16 **A.** Mm-hm.

17 **Q.** How does a focus on chasing targets lead to
18 uncompassionate healthcare, do you think?

19 **A.** I think the -- for me, a prime example of that
20 was the -- what happened at Mid Staffordshire NHS
21 Foundation Trust and one of the, the main factors there
22 that Robert Francis identified and described in-depth in
23 his Inquiry report was that that NHS Trust was so
24 focused on wanting to become an NHS Foundation Trust
25 which at the time was a new status with a set of
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1 freedoms and it was regarded as something almost to
2 become part of the -- what is the word? The first class
3 or the more elite group of Trusts.

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

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

17 **A.** Yes.

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

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

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1 **Q.** Of course, yes.

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

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

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

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

5 Yes, sorry, what was your point again?

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

8 **A.** Yes, yes.

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

11 **A.** Yes.

12 **Q.** -- to:

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

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

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

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

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

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

18 **A.** (Nods)

19 **Q.** -- in order to do your job?

20 **A.** Yes.

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

25 **A.** Yes.

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

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

25 **Q.** Indeed.

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

5 **Q.** Yes.

6 **A.** And which has both its challenges and
7 protections.

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

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

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

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1 **A.** I think it can help them as well.

2 **Q.** So regulation has two components to it?

3 **A.** Yes.

4 **Q.** One is to punish wrongdoers?

5 **A.** Yes.

6 **Q.** But another one provides a protection --

7 **A.** Yes.

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

11 **A.** Yes.

12 **Q.** And point to a Code of Conduct?

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

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

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

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

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

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

16 **Q.** Yes.

17 **A.** I think that is the --

18 **Q.** Yes?

19 **A.** -- important point.

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

24 **Q.** Yes.

25 **A.** And those, those two go together just as

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

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

14 Questions by LADY JUSTICE THIRLWALL

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

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

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

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

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

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

11 **LADY JUSTICE THIRLWALL:** Can I just --

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

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

18 **A.** (Nods).

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

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

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1 access that there is for managers.

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

5 **A.** (Nods)

6 **LADY JUSTICE THIRLWALL:** -- to the NHS.

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

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

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

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

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

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

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

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

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

25 **LADY JUSTICE THIRLWALL:** A bit like fast stream

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1 civil servants, that is something that people talk
2 about?

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

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

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

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

13 **A.** Yes.

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

22 **A.** They are.

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

25 **A.** Yes.

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

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

7 **A.** Yes.

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

12 **A.** Yes, I agree with that.

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

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

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

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1 **LADY JUSTICE THIRLWALL:** -- at high level?

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

6 **A.** Yes.

7 **LADY JUSTICE THIRLWALL:** And what works well.

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

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

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

25 **LADY JUSTICE THIRLWALL:** Yes.

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

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

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

17 **A.** Yes.

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

20 **A.** Yes, yes.

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

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

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

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

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

12 **A.** I would have --

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

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

17 **LADY JUSTICE THIRLWALL:** Yes.

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

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

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

11 **LADY JUSTICE THIRLWALL:** Yes.

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

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

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

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

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

3 **A.** Yes, I will.

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

12 **A.** (Nods)

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

16 **A.** Yes.

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

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

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

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

7 **A.** Yes.

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

10 **A.** Thank you.

11 **LADY JUSTICE THIRLWALL:** Thank you very much
12 indeed.

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

16 Evidence read by MS BROWN

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

20 **LADY JUSTICE THIRLWALL:** Thank you.

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

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

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

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

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

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

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

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

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

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

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1 practice.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 More generally, Trusts described a number of recent
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1 expressing and skin-to-skin contact was encouraged.

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

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

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

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

24 Trusts were also asked by the Inquiry to provide
25 and comment on internal policies within their
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1 actions they had undertaken, some were in response to
2 the Letby case. This included reviewing and adapting
3 policies and processes for raising concerns, incidents
4 and deaths, enhancing governance and oversight,
5 improving culture and raising awareness of routes for
6 raising concerns.

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

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

23 Amongst reasons cited by Trusts for not installing
24 CCTV within wards were privacy concerns in relation to
25 filming areas where breastfeeding, nappy-changing,
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1 organisations, including safeguarding policies. The
2 Nuffield Report notes that: about half of the
3 respondents, 61 Trusts, reported that they had reviewed
4 their policies during 2023. For most of those 39
5 Trusts, their reviews of policies were triggered by the
6 Letby case but another 10 Trusts reported reviews being
7 triggered by changes in national guidance on
8 safeguarding and/or the introduction of the new National
9 Patient Safety Incident Response Framework.

10 25 Trusts stated they had changed at least one
11 policy with the Nuffield Report commenting: for most
12 Trusts, policy changes included clarifications around
13 escalation in safeguarding processes, new checklists and
14 flowcharts when investigating neonatal deaths, updated
15 language and signposting in line with the national
16 Freedom to Speak Up policy. Among the Trusts that had
17 not reviewed or made changes to their policies, many
18 respondents suggested that they were awaiting the
19 outcome and recommendation of the Inquiry.

20 The Ian Harvey field analysis of the questionnaire
21 responses noted that the policies which were submitted
22 were lengthy, spanning numerous sections and issues.
23 Some Trusts had made changes with regard to
24 safeguarding; for example, adding a important regarding
25 escalation of concerns and the role of the Local
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1 Authority Designated Officer, the LADO.

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

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

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

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

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

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

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

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

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

25 Some Trusts have joint safeguarding policies for

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

5 Not all policies imposed a 24-hour limit on
6 referrals to the LADO and some policies simply suggested
7 that the case may need to be referred to the LADO, which
8 imports a degree of internal judgment into whether to
9 take the matter externally and does not comply with the
10 2023 statutory guidance.

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

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

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

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

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

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

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

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

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

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

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

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

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1 policies.

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

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

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

16 Some examples of good practice include:

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

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

25 (1) convene a strategy meeting to consider whether

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1 member.

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

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

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

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1 investigation under disciplinary processes is necessary
2 or appropriate;

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

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

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

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

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

23 **LADY JUSTICE THIRLWALL:** Thank you.

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

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1 doctors, nurses and managers in hospitals with neonatal
2 units.

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

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

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

20 The estimated highest response rate by occupational
21 group, 47% was from managers, followed by nurses at 30%,
22 with the lowest response rate being from senior
23 managers. Over a quarter, 25.9% of respondents, stated
24 that they had been with their Trust for more than
25 15 years.

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

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

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

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

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

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

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

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

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

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

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1 commitment to continuous improvement."

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

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

14 **LADY JUSTICE THIRLWALL:** Thank you very much
15 indeed, Ms Brown. We will take a break now so that we
16 can then start the evidence of the next witness and
17 conclude without a break so we will start again at 5 to
18 3.

19 (2.41 pm)

20 (A short break)

21 (2.55 pm)

22 **LADY JUSTICE THIRLWALL:** Ms Langdale.23 **MS LANGDALE:** My Lady, may I call the next witness.
24
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1 MR JEREMY HUNT MP (sworn)
 2 Questions by MS LANGDALE
 3 **LADY JUSTICE THIRLWALL:** Thank you, do sit down.
 4 **MS LANGDALE:** Can you give us your name and
 5 occupation please?
 6 **A.** Jeremy Hunt and I am a back bench MP.
 7 **Q.** Mr Hunt, you have helpfully provided
 8 the Inquiry with a statement dated 20 August 2024. Can
 9 you confirm the statement is true and accurate as far as
 10 you are concerned?
 11 **A.** It is, although I am no longer Shadow
 12 Chancellor.
 13 **Q.** Can you give us briefly a career history,
 14 please, and particularly tell us the period for which
 15 you were Secretary of State for Health?
 16 **A.** I was elected to Parliament in 2005 and I was
 17 an opposition spokesman for Culture, Media and Sport
 18 until 2010 then I became Culture Secretary, Health
 19 Secretary in 2012, Foreign Secretary in 2018 and then in
 20 2022 Chancellor.
 21 **Q.** You tell us in paragraph 10 of your statement
 22 your responsibility as Secretary of State for Health and
 23 subsequently Secretary of State for Health and Social
 24 Care.
 25 Can you set that out for us now, please: what's the

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

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

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

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

5 So that's the issue, that time delay.

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

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

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

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

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

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

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

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

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

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

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

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

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1 following the Morecambe Bay investigation. So it's very
2 difficult to read there, I think, Mr Hunt, you have had
3 a hard copy of this in any event but Dr Kirkup reported:
4 "There is no mechanism to scrutinise perinatal
5 deaths or maternal deaths independently, to identify
6 patient safety concerns and to provide early warning of
7 adverse trends. This shortcoming has been clearly
8 identified in relation to adult deaths by Dame Janet
9 Smith in her review of the Shipman deaths but is in our
10 view no less applicable to maternal and perinatal deaths
11 and should have raised concerns in the University
12 Hospitals of Morecambe Bay NHS Foundation Trust before
13 they eventually became evident.

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

20 "Action: the Department of Health."

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

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

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1 When you received that, was there anything specific
2 in relation to this or that recommendation that you
3 undertook, and we can go back if we want to INQ0108775,
4 which is the general chronology of how in effect it is
5 21 years later from Dame Janet Smith's recommendation
6 that finally there is a statutory footing for it in
7 2024?

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

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

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

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

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

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

16 **A.** (Nods)

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

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

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

3 **Q.** Yes.

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

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

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

16 **Q.** Yes.

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

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1 worked subsequently to discuss those in some ways.

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

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

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

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

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

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

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

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

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

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

19 He says later:

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

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

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1 spirit of his report.

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

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

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

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

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

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

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

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

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

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1 other inquiries.

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

11 **Q.** Reviews --

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

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

24 **Q.** Can I ask you to comment on two pieces of
25 evidence we have heard on related topics, the first from
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1 because there are lots of problems in the NHS and I am
2 not trying to gloss over it but, you know, by the time
3 I left as Health Secretary 4 million more patients every
4 year were being treated in "good" or "outstanding"
5 hospitals than when I started. When I started we didn't
6 even know where the "good" or "outstanding" hospitals
7 were. I think the most successful safety campaign that
8 started in my time was the Halve It Maternity Safety
9 Campaign and by 2023 the number of neonatal deaths had
10 fallen by 30% although I think there are some worrying
11 signs that it may now be going in the wrong direction.

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

14 The worry I have is what happens if you don't have
15 a Secretary of State who is totally focused on those
16 kinds of issues because, you know, something else
17 happens like for example a pandemic or something. You
18 know, it is not a criticism of the Secretary of State
19 for having different priorities. My conclusion is that
20 much of this discussion about medical error and medical
21 malpractice is ultimately about the way doctors and
22 nurses behave and if we take hospitals for a moment, it
23 is not just hospitals, I think you have to put yourself
24 in the shoes of the Medical Director of our 250 NHS
25 Trusts in England and you have to think that Medical
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1 Sir Robert Behrens, of course the former Ombudsman. He
2 said:

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

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

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

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

23 I just think in terms of context, it's important
24 not to give the impression that progress wasn't made
25 over this time. So I don't want to be at all defensive
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1 Director is technically the most senior doctor in that
2 Trust, they sit on the board and they are receiving
3 hundreds of recommendations every month, possibly
4 hundreds every week, from the CQC, from medical
5 colleges, from NHS England, from inquiries such as the
6 Francis or Morecambe Bay Reports. And they couldn't
7 possibly spend their whole time or they could spend
8 their whole time just looking through those
9 recommendations but then they won't be able to do their
10 main job which is running a busy hospital, and I think
11 what we need is something at the centre that not just
12 catalogues these inquiries, but prioritises them perhaps
13 with a traffic light system.

14 So, for example, if there's a -- I always worry
15 that if a baby died because of something that went wrong
16 in a hospital in Blackpool, you know, what you would
17 hope in the NHS is that things would change in
18 a maternity unit in Cornwall the next month so the same
19 thing couldn't happen.

20 We don't have that system in place and I think what
21 you need is a system where recommendations from Public
22 Inquiries, recommendations, things that ministers
23 decide, things that NHS England decide, that the CQC
24 recommend, that HSSIB recommends, go to a group of very
25 experienced doctors who know how you change things in
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1 the NHS. And if they think this is a safety issue, and
2 it needs to change this month they would send it out
3 with a kind of green light.

4 If it's something that needs to change but it may
5 be will take a year to do it, it will maybe have an
6 amber rating and you could have a different rating
7 a different sort of traffic light for things that are
8 nice to do if you can but not essential.

9 Because I think you have to make life easier for
10 very busy Medical Directors so they know what it is they
11 want their clinicians to do.

12 So in the case of the tragedy at the Countess of
13 Chester, I think one of the documents you asked me to
14 look at was the Beverley Allitt case.

15 **Q.** I am going to come back to that.

16 **A.** Sorry, yes, carry on.

17 **Q.** I am going to ask you to comment on the second
18 piece of evidence, thank you, you have responded in
19 relation to Sir Robert Behrens' evidence.

20 Sir Gordon Messenger gave evidence this week and it
21 was related specifically to an induction document and
22 training for senior managers but he made this
23 observation generally about directives or material being
24 put together and he says:

25 "The other observation I would have is that they
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1 that.

2 **Q.** Heightened awareness of events at Grantham,
3 deliberate harm?

4 **A.** Yes. In reality, that is actually a useless
5 recommendation if you just pump it out to 250 NHS
6 Hospital Trusts because they would -- in order to -- you
7 know, they are very, very busy, they might just send
8 an email round to everyone and say: you need to be aware
9 of the risk of malicious harm in your work and doing it.

10 The actual way which wasn't the recommendation in
11 the report, but the actual way that you could properly
12 implement the spirit of that recommendation would be to
13 say: you need to set up a system of Medical Examiners
14 and Medical Examiners need to be trained to see the
15 signs of malicious harm or patterns of harm that could
16 be malicious in their work.

17 And that is the recommendation that you can then
18 say make a big difference and you can also track whether
19 it's been implemented or not and by when. And I think
20 that translation of a well-meaning recommendation into
21 something that can have an impact on the ground in the
22 largest healthcare organisation in the world, which the
23 NHS is, is the bit that's missing.

24 **Q.** So it's what you do in practice?

25 **A.** Yes because, you know, you -- and I am,
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1 are not by any means the only organisation that I have
2 seen to do this but you spend 90% of the time on getting
3 the product right and 10% of the time on instilling it
4 in the organisation when the reality is that you should
5 probably reverse those two things and I think partially
6 because of the problems I have outlined at the beginning
7 they are sometimes despite guilty of perfectly polishing
8 a product only for it to land on an organisation that
9 either isn't ready for it or doesn't buy into it and
10 I think that needs to be more joined up."

11 And that would be a constructive observation.

12 You nod. But it sounds constructive and perhaps
13 accurate. Would you agree with that, that the
14 preparation in directives or change or encouraging it
15 might more be in the documents, the written form and it
16 needs to happen where the Medical Director and people
17 are sighted in the hospital embedding it on the ground?

18 **A.** Exactly. But it's -- but there is quite
19 an important journey that you go on. I don't want to
20 pre-empt what you are going to come on to with
21 Beverley Allitt, but can I just give one example of why
22 I think this is something that we don't do very well.

23 So there was one recommendation from the Inquiry
24 that you should raise awareness of the possibility of
25 malicious harm, I don't know the exact words but it was
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1 I think that, I mean, I was really responsible for
2 setting up of HSSIB. But when it first got off the
3 ground I didn't think its recommendations were very good
4 when I read them because they were too woolly and
5 what -- if you want to see lives saved you need to see
6 specific changes in practice on the ground. That's
7 a very difficult thing to do when you are talking about
8 very busy obstetricians and midwives in a maternity
9 unit, getting them to change their daily practice.

10 So that's why you if you are going to have
11 a recommendation you need to talk to someone who is
12 running those units, to work out the way you actually
13 would implement it in practice and that needs to be what
14 happens.

15 **Q.** Can I ask please that we have
16 Baroness Bottomley's statement on the screen, please,
17 INQ0107143, page 1. You have seen this earlier,
18 Mr Hunt.

19 If we go to paragraph 8, so those in the room who
20 won't have seen it, if we go to page 3 of the statement.
21 Give people time if we can to read 8, 9, 10, 11.

22 **A.** Yes.

23 **Q.** It's paragraph 11 and moving over to the next
24 page where Baroness Bottomley says:

25 "The decision to commission an Independent
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1 Investigative Inquiry as opposed to a Public Inquiry was
 2 one made after careful consideration and having
 3 discussed the matter with my Permanent Secretary, from
 4 previous experience of investigations into child abuse
 5 I considered that in cases such as this the truth may
 6 more readily emerge in a private investigation than
 7 a public forum where witnesses may feel under a strong
 8 external pressure and the tone more adversarial. It is
 9 also important to me that the investigation be conducted
 10 timeously so that lessons could be identified and acted
 11 on and I considered that this format would better
 12 facilitate that."

13 This of course refers to Beverley Allitt's crimes
 14 in 1991 and her appointment of Sir Cecil Clothier to
 15 investigate what had gone wrong.

16 First of all, the private versus public Inquiry.
 17 There's obviously a cost implication in that but what do
 18 you see are the considerations for determining whether
 19 there should be a public or private Inquiry?

20 **A.** I mean, I did loads of both, so I think there
 21 are pros and cons. Cost is one consideration with
 22 a Public Inquiry but also time is another consideration.
 23 They take much longer.

24 For example, I commissioned Sir Robert Francis to
 25 do a second review into the problems facing

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1 there, the focus groups or the expertise that she sought
 2 considering the recommendations and again as a matter of
 3 practice for the Secretary of State when you receive
 4 recommendations, what's done next in terms of evaluating
 5 them?

6 **A.** Well, what, it obviously depends to a certain
 7 extent on the Secretary of State. I'm not sure that
 8 there is necessarily a procedure laid out in statute.
 9 But when I was Secretary of State the practice would be
 10 that you would receive recommendations and make an
 11 initial response to them and then after you have had
 12 time to consider them in detail, because you might not
 13 see them before they are published or might just see
 14 them a couple of days before they are published, so it
 15 obviously takes you time to go through them in detail
 16 you then come back to Parliament, and you would say
 17 which ones you intended to implement and which ones you
 18 weren't going to implement and if not, why not.

19 So that I think is good practice.

20 Where it can go wrong is where there's a change of
 21 Secretary of State and a new Secretary of State comes in
 22 who isn't aware of the commitments made by a predecessor
 23 and sometimes recommendations can get forgotten or
 24 kicked into the long grass as a result.

25 **Q.** And if we go to page 9 of her statement,

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1 whistleblowers in the NHS and he did it in a year and it
 2 wasn't a Public Inquiry so he was able to do it much
 3 more quickly and I think there are times, if you really
 4 want to get on and change things quickly, where a Public
 5 Inquiry can take too long. On the other hand,
 6 I persuaded Theresa May to do the Public Inquiry into
 7 the Infected Blood Scandal and I think that was an
 8 Inquiry which needed to be public and needed to take
 9 time, even though victims were dying the whole time as
 10 a result of it.

11 So I agree with Virginia Bottomley's assessment in
 12 that. I think there are times when it's sensible to do
 13 something more quickly.

14 **Q.** If we go to paragraphs 15-17, which identifies
 15 that the report criticised failures of management and
 16 communication with the hospital, concluded delays in
 17 drawing together the different strands of evidence,
 18 prevented foul play from being identified sooner.

19 And we go over the page, please, page 6 of her
 20 statement:

21 "The report made 12 detailed Recommendations
 22 relating both to attitudes and procedures within the
 23 hospitals and individual and collective responses to the
 24 events."

25 She sets out at paragraphs 21 and 22, if we read

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1 paragraph 32, she refers to the recommendations
 2 surrounding the provision of paediatric pathology
 3 services in every case in which the death of a child is
 4 unexpected or clinically unaccountable.

5 And moving down the page, "Purpose of Inquiries and
 6 Recommendations", she sets out at paragraph 36:

7 "There may be many reasons why recommendations may
 8 not be implemented. I consider it likely that changes
 9 in ministers, Governments and those in key positions
 10 within the NHS could lead to recommendations
 11 unintentionally falling by the wayside. This is highly
 12 regrettable ..."

13 If we go to the next page.

14 "... and the fundamental purpose of Inquiries is
 15 to learn lessons from events where there have been
 16 failings, and if so, a recommendation has been carefully
 17 considered and accepted, it should be implemented.

18 "I am asked to say where I consider accountability
 19 lies. In my view, formal accountability lies with the
 20 office holder to whom the recommendation is made and his
 21 or her successors in office."

22 Would you agree with the paragraphs at 37 and 38?

23 **A.** I would, but could you possibly go back to
 24 page 9.

25 **Q.** Yes, of course.

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1 **A.** Because I just want to make a comment about
2 paragraph 2 because I just think it illustrates how
3 difficult this challenge is. So the recommendation
4 there is that paediatric pathology services should be
5 engaged in every case in which the death of a child is
6 unexpected or clinically unaccountable. It sounds
7 extremely sensible.

8 **Q.** Quite.

9 **A.** And I don't know how quickly that happened.

10 But when I was Health Secretary, I wanted to go
11 further because I was very worried about level -- the
12 high levels of baby deaths. If we had the same neonatal
13 death rate as Sweden we would have 2,000 more babies
14 living every year and I thought that was something that
15 we needed to deal with.

16 So I introduced a requirement of the NHS that there
17 should be an independent investigation into every baby
18 death, not just the ones where they were unexpected or
19 clinically unaccountable, but every single baby death.
20 So going a lot further than that, that recommendation.

21 Then I moved on and then when I came back to the
22 issue -- these reports by the way are talked about in
23 your review -- in your Inquiry documents, they are
24 called the MNSI Reports.

25 **Q.** Yes.

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1 of cut-off and you are no longer involved?

2 **A.** Well, obviously it is above my pay grade to
3 tell prime ministers how often to do reshuffles.

4 **LADY JUSTICE THIRLWALL:** No, no, I understand that,
5 but what actually were you able to do, if anything, to
6 address that.

7 **A.** I wrote a book about patient safety, I became
8 Chair of the Health and Social Care Select Committee
9 where I tried to follow up on a lot of these themes, so
10 I used my position in Parliament. But I profoundly
11 agree with you that having a minister in post for a long
12 time makes a very big difference. I mean, I think in
13 the schools sector, the fact that Nick Gibb was Schools
14 Minister for nearly a decade had a very big impact on
15 education policy and so I don't think we can
16 realistically change the fact that prime ministers are
17 going to want to have reshuffles and indeed governments
18 are going to fall and so you are going to have
19 reshuffles forced on prime ministers even if that wasn't
20 what they wanted.

21 But that is why we have a Civil Service that is
22 permanent, they are there, their job is to be that
23 institutional memory and that's why I think you need
24 to -- we need to think about what the structures are
25 that we could put in place, such that a recommendation

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1 **A.** They were done by HSSIB, they are now done by
2 the CQC and they are not working. Because what's
3 happened is that the reports are often of a poor
4 quality, they are done, they gather dust, they gather
5 dust, the box is ticked but the thing that you really
6 need to happen is not actually the report but people
7 learning from those reports and changing clinical
8 practice on the ground.

9 And that's why, and it's not easy, but you need to
10 have a structure in place which actually sees these
11 recommendations through and makes sure that the spirit
12 of what they are trying to achieve is delivered and not
13 just the box ticked.

14 **LADY JUSTICE THIRLWALL:** Can I just ask you -- I'm
15 sorry, Ms Langdale -- I see the point that you make and
16 you make some other observations in your statement which
17 no doubt we will come to. But at the time, there are
18 periods or there have been periods recently when we have
19 had really quite a turnover of health secretaries, so
20 not change of Government, just within the same
21 Government.

22 And what, if anything, did you do when you left to
23 try and encourage some sort of continuity in the work
24 that you had obviously thought a great deal about and
25 made a great deal of effort towards and there is a sort

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1 like number 32 finds its way to actual change in
2 practice on the ground much more quickly than currently
3 happens.

4 **LADY JUSTICE THIRLWALL:** Thank you.

5 Thank you, Ms Langdale.

6 **MS LANGDALE:** My question was going to be very
7 similar: what safeguards can be put in place to avoid
8 that loss of knowledge across Secretary of States? This
9 shouldn't be a political issue, should it, the
10 governance of the NHS: we should all care about the same
11 things; is that fair? And with the time you put in
12 whoever replaces you from whichever party, how do we
13 achieve safeguards to ensure momentum is maintained?

14 **A.** Well, I think on this, this specific issue,
15 which really relates to improving clinical practice,
16 reducing the risks of avoidable harm, or indeed
17 intentional harm to patients, I think we do need
18 a structure which gives absolute clarity to Medical
19 Directors about the things that they are expected to
20 change and by when.

21 I think that we should have better accountability
22 by politicians too and I think that when it comes to
23 Inquiry recommendations, and also Select Committee
24 recommendations, which is another type of
25 recommendation, at the moment, ministers have

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1 an obligation -- I think it is a legal obligation -- to
 2 respond to recommendations, but I think that there is
 3 a kind of "get out of jail card" at the moment.
 4 So with a Select Committee, you can make
 5 recommendations and the Department of Health replies
 6 within two months and it says: Recommendation 1
 7 accepted, Recommendation 2 rejected for this reason,
 8 Recommendation 3 under consideration. And basically
 9 that means they just want to think about it for longer,
 10 but often that's actually a recommendation that they
 11 don't want to implement but they don't want the
 12 embarrassment of saying they are not going to implement
 13 or they can't find the money to implement.

14 **Q.** Do they only have to say under consideration
 15 once or does it come back again --

16 **A.** No.

17 **Q.** -- two, four months later, or once?

18 **A.** Once they have given their response that is
 19 it. The box is ticked. And I think a much better
 20 system, which for both for Select Committees and for
 21 responses to Public Inquiries, is if ministers were
 22 required to do, could only do one of two things: first
 23 of all, within the statutory time period they had to
 24 respond, they have to say either they are accepting and
 25 by what date they will have implemented it, or they are

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1 a meeting between, if we go to page 3, a number of
 2 arm's-length bodies at 3 and the top of page 4. And as
 3 the title of the report might suggest, looking at
 4 recommendations but no action, the point you have made
 5 and others have made, this plethora of recommendations,
 6 overwhelming number, what do we do? How is that
 7 streamlined for those on the ground trying to follow
 8 what's being said and what's being asked of them?

9 If we look at page 4 and the findings, if we can
 10 scroll up, please, Mrs Killingback, I would like your
 11 comments on these.

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

15 Would you agree with that?

16 **A.** Yes.

17 **Q.** The second one:

18 "The noise created by the significant volume of
 19 recommendations being made means that providers struggle
 20 to prioritise and implement them"?

21 **A.** Yes.

22 **Q.** That is what you have said earlier.

23 "Some recommendations duplicate or contradict
 24 others. The development of a searchable repository
 25 which includes recommendations made across the

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1 rejecting but I think it's -- you know, I think there
 2 should be an obligation to transparency.

3 I don't think you can require ministers to accept
 4 every recommendation that is made by an independent body
 5 because there will be cost implications and they may not
 6 agree with them and ultimately they are elected
 7 representatives but I think there should be complete
 8 transparency about if they are going to implement it,
 9 when they are going to implement it by, and if they are
 10 not going to implement it, you know, truthfulness.

11 **Q.** Do you think that the House of Commons Select
 12 Committee are an appropriate mechanism for monitoring
 13 recommendations and their implementations or not?

14 **A.** They can be. Certainly when I was chairing
 15 the Health and Social Care Select Committee, doing
 16 a report on whether the Government had actually
 17 implemented the recommendations of a Public Inquiry was
 18 a perfectly sensible thing to spend time doing a report
 19 on. But it's the decision of the committee as to what
 20 to spend its time investigating.

21 **Q.** Can that document come down, please, and
 22 instead can we have the "Report recommendations but no
 23 action", INQ0108741, page 1.

24 This is a report. We heard, Mr Hunt, from
 25 Dr Benneyworth yesterday and this was a collaboration,

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1 healthcare system may help to reduce this."

2 Is that another task for someone or do you think
 3 that is a good idea?

4 **A.** I think it's a good idea but I don't think
 5 it's enough. I think just having a database of all the
 6 recommendations in maternity safety, for example,
 7 isn't -- isn't enough. What -- what the person who's
 8 running a maternity unit needs to know is what are the
 9 safety critical things that I need to do this month in
 10 terms of every single baby being born in my unit?

11 And the process of doing those safety critical
 12 recommendations, you know, obviously the people doing it
 13 need to be cognisant of the fact that that person
 14 doesn't have unlimited capacity to implement unlimited
 15 changes in working practice. So you have to have a sort
 16 of self-denying ordinance that priorities the most
 17 important things. But I think at the moment there are
 18 just so many recommendations that that things just get
 19 forgotten or lost.

20 **Q.** What's the skillset of the person or people
 21 you envisage doing that, distilling the essence of the
 22 recommendations for those on the ground?

23 **A.** Well, I think they need to be the experts in
 24 NHS England who themselves have run maternity units or
 25 been obstetricians or midwives and understand --

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1 Q. Understand the job?

2 A. -- the working environment so that they can
3 make sure they -- anything they are doing isn't -- is
4 practical.

5 I think there is one other way that you can come at
6 this which I think does happen, which is also ask the
7 CQC as part of their inspection process to see how
8 effective hospitals are at adopting recommendations and
9 improving working practice.

10 Q. Would you have the skillset that you have just
11 described within the CQC of them knowing how that should
12 be done with particular recommendations or would they be
13 relying on the people they are inspecting for what they
14 just tell them about what they are doing for that?

15 A. Well, I think the CQC has been going through
16 a very difficult patch. But when I set up CQC with
17 Professor Sir Mike Richards as the first Chief Inspector
18 of Hospitals, his approach, which I strongly endorsed,
19 was this a maternity unit should only be inspected by
20 obstetricians and midwives. And the reason that his
21 inspections were so powerful was because hospitals knew
22 that they were being inspected in every part of the
23 hospital by their peers, by people who knew what they
24 were looking at.

25 I think that was changed a few years ago and my
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1 if I could give you an example of the old CQC which
2 I changed and why we were nervous about data. So the
3 old way that we used to inspect care homes was that you
4 would send someone in their twenties in to a care home
5 and they would go straight into the office and they
6 would look at the care home's data and then they would
7 give an inspection result and that was changed to
8 a system where people who had experience of care homes
9 would actually go into the care home, talk to the
10 residents, talk to the staff and make a judgement based
11 on what they saw with their eyes and we found that was
12 a very important way of getting to the most accurate
13 results.

14 Q. If we go back to this list from the report and
15 the various findings, the penultimate one:

16 "Most recommendations made to the healthcare system
17 are not costed either in relation to the cost of
18 implementing the proposed actions or their longer term
19 cost-effectiveness."

20 Do you think there's a way that Inquiries or
21 reviews could cost recommendations before they are made,
22 is there any way there could be consultation about that?

23 A. I think that it is -- it would be a very good
24 thing for Inquiries to take more interest in the cost of
25 their recommendations because people running Inquiries
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1 understanding is it's been changed back. Professor Sir
2 Mike has actually made a recommendation which I think
3 the Health Secretary Wes Streeting has accepted, and so
4 I think it's going back to a peer review system. So
5 absolutely it's very important that, you know, GPs are
6 inspected by people who understand general practice and
7 hospitals and the social care sector are the same.

8 Q. What was your understanding -- and if you
9 can't remember, don't say -- about CQC collection of
10 data around 2015 to 2016, safety data around deaths and
11 looking for signals around deaths or unusual patterns?

12 A. Well, the CQC, the new CQC inspection regime
13 was only set up I think in the second half of 2013 and
14 by the time we got to 2015 I think they had only managed
15 one complete round of inspections of hospitals.

16 But they were I think rather rightly nervous of
17 over-relying on data in their inspections because in
18 order to get a very -- a proper assessment of the
19 culture in an organisation, they believed -- and
20 I agreed with them, that you need to go somewhere and
21 feel what it's like and talk to people and over -- and
22 data can be manipulated and an overreliance on data
23 sometimes means that the inspectors become a bit
24 distant.

25 So I am not minimising the importance of data but
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1 like yourself, my Lady, are very keen to make sure that
2 their recommendations are implemented and often the
3 reason that things are not implemented is because of
4 cost. I think that was the fundamental issue with the
5 recommendation on Medical Examiners; there was a cost
6 involved asking every hospital in the country to
7 allocate doctor resource to examining every death that
8 happened in that hospital.

9 So I think it can give you a clue as to where there
10 are likely to be the most difficulties in
11 implementation.

12 But I think there is a bigger reason why, but
13 I don't think you could expect Inquiries necessarily to
14 know the costs of everything that they are opining
15 about.

16 But if you had a central structure that was looking
17 at the recommendations on patient care that were coming
18 in from Royal Colleges and the CQC and Public Inquiries,
19 they would know the cost because it would be, you know,
20 part of NHS England perhaps. And I think that they
21 would then be able to prioritise. Things that are free
22 we should do straight away without any hesitation.
23 Things that cost money, we should be reasonable that
24 organisations are going to have to find resource to do
25 it and maybe you give people a timescale within which
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1 they have to do that and that is part of the way that we
2 will have a more structured system where we have
3 confidence that what we want to happen does actually
4 happen.

5 **Q.** Do you think new recommendations should
6 explicitly supersede previous recommendations by reviews
7 or Inquiries if they are very specifically related?

8 **A.** I think that you would hope that if a new
9 recommendation was made that had an impact on a previous
10 recommendation it would be explicit that this
11 recommendation is replacing a previous recommendation.

12 But I think that's why you need someone centrally
13 aggregating all these recommendations and then making
14 a decision as to what it's reasonable to ask a Medical
15 Director to implement in their own hospital.

16 **Q.** When you say centrally, do you think this
17 should be for NHS Inquiries and reviews as opposed to
18 Public Inquiries generally. There's been some
19 discussion, as you know, about a unit on the face of it
20 potentially to look at Public Inquiries' recommendations
21 or do you think the NHS has so many recommendations it
22 is very specific and a very large organisation deserving
23 of itself --

24 **A.** I think the solution that we came up with was
25 just about Public Inquiries because when you look at the
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1 Secretary of State for Health to provide detailed
2 reasoning for not implementing any recommendations
3 within 12 months of them being made?

4 So slightly shorter period, certainly transparent
5 but 12 months subsequent to a report, the Secretary of
6 State reasoning what is being implemented and what isn't
7 and why are publicly available?

8 **A.** Yes. I mean, I don't have a particular view
9 about the timescale. I think it will depend on the
10 Inquiry and the nature of the recommendations. But
11 I think it would be a good practice to have a kind of
12 a standard rule with Public Inquiries that after a fixed
13 timescale, the person in charge of the Inquiry gives
14 a verdict as to whether what they have said has been
15 taken seriously by the Government or not.

16 **Q.** If we can go, please, to page 7 of the
17 document on the screen, "Recommendation Registers".

18 We see at the bottom:
19 "NHS has developed a National Recommendations
20 Register for Maternity and Neonatal Services."

21 That presumably could be replicated in other areas,
22 couldn't it, as well?

23 **A.** Yes. I don't know how well the National
24 Recommendations Register for Maternity and Neonatal
25 Services is working in the NHS at the moment. I am --
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1 NHS, there are so many other recommendations that are
2 important from the CQC or HSSIB or, you know --

3 **Q.** NICE?

4 **A.** NICE, exactly. There so many other ones that
5 come up so I think actually the NHS needs a single way
6 of knowing what it's expected to do and by when with
7 total clarity.

8 One innovation and I am just sort of thinking off
9 the cuff here, I wonder whether in terms of all Public
10 Inquiries one of the things we should do is ask the
11 judge responsible for a Public Inquiry to do
12 a subsequent report, maybe two years later, which
13 formally assesses the extent to which their
14 recommendations have been implemented.

15 That might be a way to jolt the system to implement
16 stuff that's been put in the long grass and I don't
17 think they would be able to pull the wool over the eyes
18 of any judge so that would encourage transparency
19 because I think it would mean that where you weren't
20 planning on implementing a recommendation it would
21 encourage you to say so up front and explain why. But
22 it would perhaps make it more difficult for people to
23 kick stuff into the long grass.

24 **Q.** Indeed that is one of the questions from our
25 CPs: should Inquiries have the power to request the
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1 I am a bit nervous about -- I mean, I think it's a good
2 idea to have a register but I think what really matters
3 is what people are asked to change and by when. And
4 just cataloguing all the different things that might be
5 good to do isn't in my experience going to be enough.

6 **Q.** If we go back -- that can come off the screen
7 -- to your statement, at paragraph 37, Mr Hunt, you were
8 asked to explain the effective decision not to implement
9 recommendations and the consequences for the Government
10 and Government departments concerned and there is no
11 formal sanctions.

12 What is your view about that, that there is no
13 formal sanctions in those circumstances?

14 **A.** I think the way our democracy works is that
15 accountability sits with Secretaries of State and they
16 therefore should be the ones that make the final
17 decision as to whether to implement a recommendation.
18 But what I don't like is the way that it's so easy to
19 push into the long grass recommendations that you don't
20 want to implement and not be accountable for that.

21 **Q.** Indeed there is some scepticism in some
22 quarters, isn't there, that setting up a Public Inquiry
23 might be doing exactly that: pushing it down and not
24 actually intending to do very much when the
25 recommendations come back?
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1 A. Yes.

2 Q. You nod, but what is your view about that?

3 A. I think that sometimes, you know, that
4 probably is the case. I found the opposite, what
5 I found was that, you know, not just Public Inquiries
6 but when I commissioned Inquiries, it was a forcing
7 mechanism. I was -- you know, because obviously if you
8 choose someone who's respected to do the Inquiry, as for
9 example Sir Robert Francis was, then his recommendations
10 carry a lot of weight and I was very keen to change the
11 culture in the NHS to be more of a learning culture and
12 I found that having clear recommendations from
13 Sir Robert made that much easier.

14 So his Freedom to Speak Up Report that he did
15 recommended that we have Freedom to Speak Up Guardians
16 in every hospital which is an independent person any
17 doctor or nurse can contact if they have concerns about
18 patient safety and the way they are being asked to do
19 things. That actually has been one of the most
20 successful things that's happened in the NHS in the last
21 10 years, I think it's broadly been a successful reform,
22 unlike the independent report on every child death which
23 has -- I think it can be a very important reform and
24 I hope we make it work but I don't think it has been
25 successful to date.

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1 And, you know, in every other field -- not every
2 other field but in most other fields, in your field and
3 my field we make mistakes the whole time but someone
4 doesn't die.

5 If you make a mistake and someone dies it is
6 an incredibly difficult thing but most -- most -- nearly
7 all doctors I have ever met all they want to do when
8 that happens is to learn from what went wrong and make
9 sure that they and their colleagues never make the same
10 mistake again.

11 If, as happens for example, when babies die on
12 maternity units the lawyers are called in, there is
13 a five or six or seven-year period of litigation because
14 the parents, quite understandably, want to get a big
15 financial settlement if they have got to bring up, for
16 example, a disabled child with enormous cost, doctors
17 are worried about their professional reputation,
18 battle-lines are drawn, and even five years later when
19 a court decides what actually happened, often very
20 little is learned or changed on the ground because
21 everyone says "that's something that happened five years
22 ago" and we have to change that culture.

23 But because there is so much of that happening, as
24 I say I think 13,500 preventable deaths every year in
25 the NHS, by the way, that is about the average

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1 So I think those Inquiries are good ways of making
2 stuff happen.

3 Q. You refer at paragraph 49 in 2015 to the
4 publishing of "Learning Not Blaming" and it's clear it's
5 important not to stigmatise for mistakes, isn't it,
6 particularly when they are part of a collective failure
7 and there needs to be a system change? But in those
8 rare cases where deliberate harm has been caused by
9 someone, it is very different, isn't it? There is
10 a need to be responsible and blame in some cases?

11 A. (Nods)

12 Q. Again you nod, but how do you differentiate
13 between the two, how do you know on the ground which you
14 are dealing with?

15 A. Well, I -- it's obviously a difficult
16 challenge but I think it's completely solvable. And
17 I think the key here is openness and transparency and
18 the -- I think one of the problems at the moment is that
19 if a doctor makes a mistake they are worried that if
20 they are open about that mistake, they will lose their
21 job because in the end it's easier for a hospital to
22 fire a doctor and say: I am very sorry about what
23 happened but we had a rotten apple but we have got rid
24 of him or her, than to change working practice on the
25 ground.

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1 internationally, so this is not just an NHS theme, when
2 you have the egregious cases, the Shipmans or the
3 Letbys, they are less likely to get spotted in a context
4 where there is so much other preventable death that is
5 going on.

6 At the same time, of course, I think it's very
7 important that Medical Examiners understand that
8 tragically once in a while there will be malicious
9 actors and you have to have that in the back of your
10 mind the whole time.

11 But I think it would be much, they would become
12 much more apparent much more quickly if we had better
13 structures in place for dealing with the majority of
14 deaths which are actually caused by error by people who
15 are really trying their hardest.

16 Q. And you indeed say at paragraph 64 you would
17 recommend moving to a no fault compensation scheme.
18 Would you like to elaborate upon that?

19 A. Yes. I mean, there are, you know, countries
20 like Sweden and New Zealand have been able to foster
21 a much more transparent culture by saying to -- in the
22 case of Sweden, if they make an assessment that somebody
23 has been harmed because of medical error, compensation
24 is automatic without having to go through a legal
25 process and without having to attach blame to

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1 an individual doctor. And they take the sting out of
2 those problems and they have a much more transparent
3 culture and as I say, a safer culture because fewer
4 babies die than happens in UK.

5 In New Zealand they have gone even further and they
6 just have a menu of compensation that is paid to people
7 who are harmed in the system.

8 Those systems actually, I looked at that system
9 when I was Health Secretary and I was told by my
10 officials that it was more expensive because most people
11 don't claim for -- when they are harmed by the NHS.
12 Under that sort of system you would automatically pay
13 everyone who is harmed. It actually turns out it costs
14 New Zealand less than clinical negligence costs us here.

15 **LADY JUSTICE THIRLWALL:** Pro rata or?

16 **A.** As a proportion of the cost of the healthcare
17 system.

18 **LADY JUSTICE THIRLWALL:** Right, okay.

19 **A.** We pay more --

20 **LADY JUSTICE THIRLWALL:** Yes.

21 **A.** -- for our system than New Zealand pays with
22 its menu-based no fault system.

23 **MS LANGDALE:** You say in your statement -- your
24 final paragraph says:

25 "... when it comes to the implementation of
221

1 eye perhaps to the deliberate acts of harm?

2 **A.** Maternity safety was always one of the areas
3 I was most concerned about. You know, the clinical
4 negligence settlements cost the NHS about £4.5 billion
5 every year which is money that is not being spent on
6 doctors and nurses but compensating families for harm
7 that should not have happened and I think that it's
8 an area that we should continue to do more on.

9 We made good progress I think in the second half of
10 the last decade, but over the last few years I think
11 because the NHS has been under so much pressure with the
12 pandemic, the indicators have started to go back again
13 in the wrong direction and I think it would be --
14 I think it should be a very big priority. I think it is
15 a priority, by the way, for the current Health
16 Secretary, to renew effort on maternity safety, but it's
17 not just maternity safety.

18 You know, the safety of patients having hip and
19 knee replacements, the safety of patients in general
20 practice who get a wrong diagnosis. These are all areas
21 and I would say that in the end they come back to
22 culture and whether you have an open and transparent
23 learning culture where doctors feel able to discuss
24 mistakes they may have made and confident that if they
25 do that, they will be treated fairly and that's the
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1 recommendations, whether statutory or not, I recommend
2 a beefed-up version of the requirements placed on
3 governments to respond in a timely way to Select
4 Committee reports, the government should have
5 an obligation to respond within 60 days to all
6 recommendations with a straight 'yes' or 'no' answer."

7 Accept no "under consideration" type principle?

8 **A.** I would just add to that I think if they say
9 yes, they need to give a date by when because otherwise
10 again it can be just delayed and delayed and delayed.

11 **Q.** What about -- we have seen you have done it
12 with the other reviews you have commissioned, and
13 Baroness Bottomley did it in discussion groups what
14 about if you need to follow up or have further
15 discussions with affected parties giving dates for that
16 ie timetabling anything they intend to do?

17 **A.** Yes, absolutely.

18 **Q.** Finally, we asked for any reflections on
19 enhancing the safety of babies in hospital generally.
20 This Inquiry is looking at the wider NHS and
21 particularly looking at babies.

22 Do you have any comments about that that you would
23 like to make? I don't mean detailed policies but
24 general views or from your experience what you would say
25 keeping babies safe in hospital and with a particular
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1 thing that fundamentally is the issue that we need to
2 address.

3 **Q.** And how are doctors to be made to be feel
4 valued in the system because that is clearly important
5 for a culture, isn't it, to feel valued and respected?

6 **A.** Well, I think that if you look in the NHS you
7 can see brilliant hospitals where they have exactly the
8 right culture and that happens. I mean, Salford Royal
9 was particularly well known for it, Worthing and
10 Chichester Hospitals had a brilliant learning culture
11 when I was Health Secretary.

12 **Q.** How was that done? What did you observe, how
13 did they achieve that, do you think?

14 **A.** When I visited Worthing Hospital, I remember
15 being taken to an upstairs room where there was a wall
16 of Post-It notes which were suggestions from clinicians
17 as to how they could improve the care they were giving
18 to patients, so it's -- I think one of the most
19 impressive hospitals in the world is Virginia Mason
20 Hospital in Seattle, it is very famous for its safety
21 culture and they were the best I ever saw in terms of
22 creating a supportive culture in which clinicians feel
23 able to speak if they made mistakes. And we set up
24 a collaboration with Virginia Mason and I think they
25 coached about eight NHS hospitals in how you get that
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1 culture right.

2 I don't think you can impose culture from the top,
3 I don't think you can have a Health Secretary or a Chief
4 Executive of NHS England who says, you know, "thou shalt
5 be open, thou shalt be supportive to people who talk
6 about", it's something that has to come from inside.

7 **Q.** Inside the hospital, leaders at all levels?

8 **A.** Absolutely, it needs to come from the leader,
9 the Chief Executive and the board of the hospital and
10 the people running all the different departments in the
11 hospital but it has to come from inside.

12 In the end, if you are going to have the confidence
13 to be open and transparent you have to see your line
14 manager behaving in that way and that line manager has
15 to see their line manager behaving in that way. So it,
16 it needs to be fostered from the, from the very bottom
17 up.

18 **Q.** Do you think there is any sign of an ability
19 to take constructive criticism, you speak of performance
20 management, people do, but discussion amongst clinicians
21 across people working in a hospital in a reflective way
22 where you might be getting things wrong. Are those
23 important features of day-to-day working in an open
24 culture?

25 **A.** They are and the best hospitals in the country
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1 your witness statement that although the report was very
2 specific to the events that happened at
3 Mid Staffordshire you felt that the whole health and
4 care system needed to listen, reflect and act in
5 relation to the key challenges of culture and behaviour
6 that the report highlighted.

7 My reading of that statement that you have made is
8 that you believed that there were other wider issues and
9 problems in terms of culture and behaviour -- and by
10 that I am going to insert the word "negative" before
11 each -- within the NHS and the healthcare sector widely;
12 Is that correct?

13 **A.** Correct.

14 **Q.** In relation to that culture, this Inquiry has
15 heard a lot of information from those clinicians who
16 were working at the Countess of Chester at the time and
17 others who have been involved within the healthcare
18 sector more generally.

19 The challenges are partly to do with attitudes of
20 management and you have used the examples fairly
21 recently of the hospital in Seattle which was possibly
22 you said the best.

23 But one of the other themes that has developed in
24 the evidence is that part of the problem with culture
25 and behaviour arises from the structure which has
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1 and the best hospitals in the world absolutely have that
2 and to go back to your earlier point, I suspect that if
3 you have that constructive culture, you would spot
4 a malign actor much more quickly because what happens in
5 those hospitals is that they are constantly looking at
6 patterns and data and saying: how can we learn how can
7 we improve this? So if you identified a high number of
8 fatalities where patients under the responsibility of
9 a particular doctor or a particular nurse then they very
10 quickly talk to that person to try and understand what's
11 happened.

12 And so I think it would be -- we would be much more
13 likely to spot malign actors more quickly.

14 **MS LANGDALE:** Thank you, Mr Hunt. Those are my
15 questions. I am not expecting any but ... there are
16 a couple. Thank you.

17 **LADY JUSTICE THIRLWALL:** Mr Sharghy.

18 Questions by MR SHARGHY

19 **MR SHARGHY:** Mr Hunt, good afternoon, I ask
20 questions on behalf of one of the Family groups involved
21 in this Inquiry. And I would like to pick up if I may
22 in relation to shortly after you became Secretary of
23 State for Health and you received Sir Robert Francis's
24 Report, I think you say in your witness statement about
25 six months into your tenure, you say at paragraph 17 of
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1 developed throughout the NHS, too many committees, not
2 enough time for clinicians to devote their efforts
3 towards the clinical side of their role as opposed to
4 the management side of their role.

5 How much of that was on your radar during your
6 tenure as Secretary of State?

7 **A.** Well, I -- I very much agree with that and
8 I came to realise that there were some big problems in
9 the structures of the NHS that made it difficult to
10 develop the constructive culture that I felt we needed.
11 And in particular, I think there are too many targets.
12 And I think that if you look at what is different about
13 the way the NHS runs to nearly every other healthcare
14 system in the world, it will be that a Chief Executive
15 of a hospital will be assessed against possibly 100
16 targets every year and they spend a lot of their time
17 trying to tick boxes to show that they are hitting
18 a particular target in this department or a particular
19 target in that department, and frankly it means they are
20 rushed off their feet and they are worried about the
21 numbers that they are going to be giving to NHS England
22 the next month and it crowds out the opportunity for
23 longer term strategic changes, including improving the
24 culture. But not just that, things like putting in
25 place a new IT system which could transform efficiency
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1 in the organisation that, kind of thing, tends to get
2 crowded out because they are being kept on such a short
3 leash by their managers in NHS England and I do think
4 that is culturally very bad for the NHS.

5 **Q.** Those targets have been consistent for the
6 last several decades. What's the solution?

7 **A.** To get rid of them. I think that we have
8 a much better system in the way we regulate our schools
9 than the way we regulate our hospitals. We don't give
10 the Education Secretary a national target for the number
11 of physics A Level passes but if we did, the Department
12 for Education would be on the phone to every secondary
13 school in the country hassling them to get more people
14 to study physics and you create a huge bureaucracy,
15 which is basically what NHS England is.

16 I think, you know, we have the CQC. If it -- if
17 it's got back on its feet, which I am sure it will be,
18 it goes round and looks at safety, quality,
19 responsiveness. But I think the targets that we have
20 are -- make it very difficult to develop
21 a patient-focused culture because people are much more
22 interested in managing up than managing down.

23 **Q.** Thank you.

24 You were taken to the chronology regarding Medical
25 Examiners by Ms Langdale and I am not going to take you
229

1 I don't, I completely understand why people might
2 support it. But I don't think it quite works to have
3 an independent body because the issue is really about
4 implementation and it's making change happen and
5 an independent body isn't able to make change happen in
6 the way that NHS England can.

7 So I would I think the body that decides on whether
8 these -- first of all ministers need to decide which
9 recommendations they are going to accept and the
10 minister having decided which recommendations they are
11 going to accept, then you need people who understand
12 what happens on the ground in the NHS to decide how that
13 recommendation is going to be implemented and I think
14 that needs to be part of the NHS management structures
15 because they are the people who have Executive authority
16 over hospitals and GP surgeries and so on.

17 But I think the way that you achieve the result you
18 want is that what they say should be transparent.
19 I think everyone should know.

20 I think, my Lady, if you make a recommendation that
21 ends up being something that you want changed in every
22 hospital in the country, you should be able to see that
23 the minister accepted it, then that went to this
24 Management Team in NHS England and they said: we agree
25 and we are going to make that happen by November 2026,
231

1 through the detail but we are talking about a 21-year
2 period from when the recommendation is first mentioned
3 by Dame Janet Smith to when it's fully implemented.

4 Within that time, we have had eight prime ministers
5 including the current incumbent and 12 Health
6 Secretaries, I think yourself being the longest in post.
7 In relation to just that one recommendation, you have
8 accepted that that is an inordinately long period not to
9 say that progress wasn't made. But doesn't that make it
10 even more feasible to have an independent body that
11 oversees the myriad of recommendations that come from
12 Public Inquiries HSSIC, Coroners I think is another one
13 that can be mentioned. They produce Rule 28 reports all
14 the time suggesting recommendations and it deals with
15 a baby harmed in Blackpool, learning lessons in Cornwall
16 so that the same thing doesn't happen again.

17 Do you agree with that proposal, so that there is
18 an independent oversight body that can amalgamate the
19 thousands of recommendations that are made, that can
20 monitor implementation, that can look at alternatives,
21 cost benefit analysis and then perhaps present that to
22 the Health Secretary of the day and have carriage of
23 challenging, if necessary, where implementation is
24 delayed or indeed not carried out?

25 **A.** I -- I would tweak that suggestion actually.
230

1 and all hospitals will be asked to do that by
2 November 2026 and then there's complete transparency and
3 everyone knows where they stand.

4 If it was a very expensive recommendation it might
5 be that the decision was to implement it by
6 November 2028 and everyone knows where they stand and
7 there is honesty and transparency, I think that is the
8 way that I would do it.

9 **Q.** Presumably one of the most persuasive things
10 to a Health Secretary is whether or not a recommendation
11 that an Inquiry or another organisation makes is in
12 relation to an isolated issue or incident or whether
13 these problems have arisen not just in the past but
14 elsewhere and it's that which I was more focusing on
15 than an independent body can amalgamate because at the
16 moment, as far as I understand, there is no single
17 organisation or body that looks at the entirety of the
18 recommendations that come from the different sources to
19 see how widespread a particular issue or problem is, to
20 then try and persuade a Secretary of State that this
21 issue is quite prevalent, it is immediate and action
22 needs to be taken.

23 **A.** Well, I think that should be the job of HSSIB,
24 I mean, they are an independent investigations body,
25 they have autonomy over what they investigate and where
232

1 they think that there is clinical practice that is wrong
 2 and causing harm have the ability to launch an
 3 investigation and I think when they make a
 4 recommendation as a result of those investigations, it
 5 should then go to this transparent group of people in
 6 NHS England who say if the minister said this is going
 7 to happen, this is when it is going to happen and this
 8 is how it is going to happen and we are sending the
 9 instructions to hospitals to do (a), (b) and (c) and
 10 that is the bit of the process that's not happening at
 11 the moment.

12 **Q.** Thank you. The Inquiry has also heard a lot
 13 of evidence in relation to what we have referred to as
 14 corporate memory, I think you refer to it as
 15 institutional memory, do you also accept there is such
 16 a thing as political memory; in other words, the
 17 Government of the day, as Secretary of State, the
 18 priorities that they bring to healthcare issues in
 19 particular. Is there any way that there could be better
 20 continuity in relation to political memory?

21 **A.** It's difficult because, you know, we are
 22 a democracy and Prime Ministers lose the support of the
 23 House of Commons and then they resign and there's --
 24 I think there's always in a democracy going to be an
 25 element of political turbulence.

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1 able to do that but I think if you were going to do one
 2 thing that made the culture of the NHS more
 3 patient-focused it would be to get rid of this huge
 4 number of centralised targets that we have.

5 **MR SHARGHY:** Thank you.
 6 My Lady, thank you.

7 Questions by LADY JUSTICE THIRLWALL

8 **LADY JUSTICE THIRLWALL:** Thank you.
 9 Did you say more than a hundred targets each year?

10 **A.** Yes. I mean it's -- you know, they will have
 11 a whole bunch in their cancer unit, in the A&E and the
 12 elective care and, you know, it's -- and GPs have got
 13 about 80 through their QOF system. So we have gone
 14 target-mad in the NHS.

15 **LADY JUSTICE THIRLWALL:** And the reason for that
 16 being? What do people think targets achieve?

17 **A.** It started with Tony Blair.

18 **LADY JUSTICE THIRLWALL:** I don't -- sorry, I hope
 19 you don't think me impertinent, I don't want a great
 20 long history, it's more --

21 **A.** No, no, I will give you a brief answer.

22 **LADY JUSTICE THIRLWALL:** All right.

23 **A.** He wanted to improve the NHS and very
 24 reasonably said: we are going to have a target for A&E
 25 and a target for elective waiting times.

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1 I do think that where we have had the best results
 2 in terms of improving public services has been where
 3 people have stayed put for a long time and so I, you
 4 know, were any Prime Minister to ask me I would say try
 5 to keep your ministers in post for a long period of time
 6 if you possibly can because that is how you get the best
 7 results. But I think that we should recognise there
 8 will be chopping and changing in Westminster, that is
 9 part of our system and therefore we need to have
 10 structures outside the politicians who have ultimate
 11 responsibility to make sure that there is that
 12 institutional memory.

13 **Q.** Thank you. Final question. If you were able
 14 to have your time again, what is the one aspect of
 15 patient safety that you would seek to implement?

16 **A.** I wish I had done more to dismantle targets
 17 because I think they make the NHS the most centralised
 18 system in the world and they create the wrong culture.
 19 Everyone is trying to please their manager in
 20 NHS England.

21 I wasn't hitting my targets when it came to A&E and
 22 elective waiting times. So I thought if I scrap targets
 23 now everyone will think it is because I am not hitting
 24 them, so my plan was to hit the targets and then scrap
 25 them and unfortunately I never got to the point of being

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1 **LADY JUSTICE THIRLWALL:** So about waiting times,
 2 yes.

3 **A.** And this is the way I am going to grip the
 4 system. But since then, it's been rolled out every
 5 other area and every new Health Secretary has come in
 6 with their own set of targets, including we with patient
 7 safety targets.

8 So I wasn't completely innocent of this. So that's
 9 why it's become incredibly unwieldy.

10 **LADY JUSTICE THIRLWALL:** Thank you. You are not
 11 the first person, I have to say, to say that the
 12 suggestion might be to get rid of targets as a general
 13 proposition.

14 Going back to the point you were making about
 15 culture earlier and saying that can't be dictated by the
 16 Secretary of State or indeed a Government minister, but
 17 is there not something in the suggestion that the
 18 Secretary of State might set the tone for culture
 19 because one of the things one does observe is a sort of
 20 culture of fear that everyone is afraid of the person
 21 above them so even the people -- or not all of the
 22 people but many of the people at the top are afraid of
 23 what the Secretary of State is going to make of things.

24 So isn't there some responsibility within the
 25 Secretary of State and the other ministers for setting

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1 the tone for culture?

2 **A.** I think there is more than some
3 responsibility, they have an absolute duty to set an
4 example.

5 **LADY JUSTICE THIRLWALL:** Yes.

6 **A.** But -- and you have to set an example but in
7 the end, you can't change things like culture by diktat.

8 **LADY JUSTICE THIRLWALL:** That I completely
9 understand.

10 **A.** I think one of the problems is that
11 politicians in particular find it very difficult to
12 accept blame because we are punished so heavily in the
13 media if -- if we were to -- if Keir Starmer were to get
14 up tomorrow and say "I think I got this wrong and that
15 wrong in the last six months" you can imagine the huge ^
16 media furore there would be and so we find it very
17 difficult.

18 But I think we should find ways to make it easier
19 for doctors and managers in the NHS because they are not
20 elected politicians and they should be supported to be
21 open and transparent in a way politicians perhaps can't
22 be.

23 **LADY JUSTICE THIRLWALL:** Yes. Thank you. Going
24 back to Medical Examiners, and we have rehearsed the
25 timetable, I just want to, if I can, pinpoint it a bit

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1 **A.** I don't think it was related to the Letby
2 conviction. It was because it was something that
3 I wanted to do for reasons of patient safety.

4 **LADY JUSTICE THIRLWALL:** No, I understand why you
5 wanted to do it but I am trying to work out why it came
6 across your desk in 2023.

7 **A.** Because I was aware that it was
8 a recommendation that had not been implemented because
9 the Treasury had concerns about the cost of it.

10 **LADY JUSTICE THIRLWALL:** Right. So what happened,
11 you said "I want this implemented", so it didn't come
12 across your desk; you instigated it.

13 **A.** Yes, I instigated it but I -- and I can't,
14 my Lady, I'm afraid exactly remember when but I suspect
15 it was part of a package of other financial support for
16 the NHS which I said this needs to be part of.

17 **LADY JUSTICE THIRLWALL:** All right, so that's 2023
18 and how much was involved, how much money did it cost
19 because you said you made the money available.

20 **A.** I'm afraid I can't remember. If I were to
21 guess, it would be something like £40 million a year.
22 But I think it's something that we should perhaps ask
23 the civil servants to tell us.

24 **LADY JUSTICE THIRLWALL:** Yes, I am sure we could
25 ask somebody, but just in case you remembered it, but it

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1 more precisely.

2 You said it came across your desk in 2023 when you
3 were back as Chancellor, I think that was 2022 was it?

4 **A.** I became Chancellor in October 2022.

5 **LADY JUSTICE THIRLWALL:** October 22 and 2023 was
6 when it came back over your desk. And it was something
7 you told us that the NHS didn't want so I just wondered
8 in what circumstances it came across your desk?

9 **A.** Well, when I say the NHS didn't want, I think
10 it's important to say that I am sure the NHS thought it
11 would be an excellent thing to have Medical Examiners.
12 But the issue was the cost of it and whether that money
13 would have to be diverted from other priority areas and
14 also the capacity, the number of the doctor hours
15 available and whether, if you were going to be asking
16 doctors to be Medical Examiners, that would mean they
17 weren't available to treat patients with.

18 **LADY JUSTICE THIRLWALL:** Yes, and you have
19 explained that earlier. But the bottom line was it
20 hadn't happened and so far the NHS didn't want it to
21 happen for all those reasons.

22 **A.** Yes.

23 **LADY JUSTICE THIRLWALL:** But then a time comes when
24 it comes across your desk in 2023. Was that after the
25 conviction of Lucy Letby?

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1 is in the tens of millions which was made available --

2 **A.** Yes.

3 **LADY JUSTICE THIRLWALL:** -- presumably to set the
4 thing up and then that continued while you were
5 Chancellor anyway to be included in the NHS budget.

6 **A.** I think it started from sort of 2024, didn't
7 it?

8 **LADY JUSTICE THIRLWALL:** Yes, well, I think the
9 legislation became effective on the day we started this
10 Inquiry. I think that was entirely by coincidence, it
11 was 9 September of last year.

12 **MS LANGDALE:** I think the framework, my Lady,
13 was -- came in in October 2023 and in statutory force in
14 September, that's right.

15 **LADY JUSTICE THIRLWALL:** Thank you. I am just
16 going to go back to the question of your discussions
17 with Sir Robert Francis because the general approach, as
18 you know, as the Chair signs a report, it goes to the
19 minister and goes to Parliament and that's the end of
20 the involvement of the Chair.

21 But it sounds as though you clearly did have an
22 ongoing discussion. Was that something that was formal
23 or was it something that Sir Robert was doing
24 voluntarily? How did that come about?

25 **A.** He was doing it voluntarily.

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1 **LADY JUSTICE THIRLWALL:** Yes.

2 **A.** Because he was very keen to see his
3 recommendations implemented.

4 **LADY JUSTICE THIRLWALL:** To see it through,
5 I understand that. And you were of course open to that
6 so of course a different Secretary of State who wasn't
7 so keen on whatever recommendations were made, I don't
8 mean necessarily in this context but you would not
9 necessarily assume that you would have that sort of
10 relationship between the Secretary of State and the
11 writer of a report, it would depend on the
12 recommendations I suppose and the people --

13 **A.** That's why I wonder if there was a formal
14 obligation on the person chairing the Inquiry to make
15 a public statement a period of time later, that might
16 excite interest.

17 **LADY JUSTICE THIRLWALL:** Yes, and it may give
18 a framework for that sort of discussion.

19 Yes, the other thing you mentioned, we haven't
20 really touched on it today, but in your statement was
21 the difficulty of having any testing of recommendations
22 before the report.

23 I have to say that because there were suggestions
24 made by parents in this case for example in relation to
25 CCTV, that is something that everyone has been asked
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1 recommendation within let's say a year or, let's say
2 a year and to say if they are going to say either yes or
3 no and if it's yes, by when.

4 So there is transparency and there is a political
5 commitment at that point that this will be in place by
6 a certain time. It would then go to the NHS England who
7 having had that and if it costs money the minister will
8 have had to find the money to do that.

9 It would then go to NHS England who would then give
10 the instructions to Trusts as to precisely what they
11 need to do by when. But I don't think you can avoid the
12 fact that there will always be difficult calls to be
13 made over money. I think that what we can do better
14 than we are doing now is to create a transparency so
15 that when ministers decide things aren't affordable they
16 are open about it rather than just shuffling it to the
17 right.

18 **LADY JUSTICE THIRLWALL:** Going back to the point
19 about money. There are as you have said a lot of
20 targets and a lot of time and effort and therefore money
21 is being spent chasing the targets and should I infer
22 from what you have said that if we get rid of targets
23 that will free up a lot of time?

24 **A.** Yes.

25 **LADY JUSTICE THIRLWALL:** It won't leave the time
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1 about including NHS England and we have got their
2 response to that.

3 So to some extent anyway we have looked at the
4 practicability of some of the suggestions.

5 Going back to the point that you have made about
6 having a bespoke unit, if you like, whose responsibility
7 it is to respond to and deal with recommendations, and
8 I understand what you say about the fact that it ought
9 to be internal to the NHS, ie people who know the NHS
10 well and are able to understand what the problems are.

11 How realistic is it, I mean, if we just rewind to
12 the clinical examiners, the Medical Examiners point and
13 we know that the expense was such that that wasn't
14 something that the NHS wanted to push until -- and
15 obviously they were very happy to push it, I am sure
16 once you made the money available. But what about the
17 mindset that is always: I understand why this can happen
18 but it's super-cautious about doing anything which is
19 going to cost money because of the knock-on effects
20 elsewhere in the system. How would you guard against
21 that? Because it's difficult to see that Medical
22 Examiners were other than a really good idea.

23 **A.** So I think what I would do is this: you know,
24 you have a recommendation for Medical Examiners. The
25 minister has a statutory obligation to respond to that
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1 empty, but it will leave time for other things to be
2 dealt with?

3 **A.** That, that's what I believe. To be clear,
4 I think it's a very good thing that the Government is
5 prioritising bringing down waiting times, you know, they
6 are too long.

7 **LADY JUSTICE THIRLWALL:** Yes.

8 **A.** So I am not wanting any fewer people to be
9 treated.

10 **LADY JUSTICE THIRLWALL:** No.

11 **A.** But I would rather that was monitored on
12 a hospital by hospital level and with hospitals assessed
13 transparently by the CQC as to whether they are doing as
14 good a job as they could and treating as many people as
15 quickly as they can. What worries me is that so much
16 management, a lot of these targets are monthly targets
17 and they absorb a huge amount of focus from the people
18 running hospitals and it makes it very hard for them to
19 focus on things like improving culture or clinical
20 practice so I hope it would free up time for more
21 strategic longer-term thinking by the people responsible
22 for hospitals.

23 **LADY JUSTICE THIRLWALL:** And would that change,
24 I mean your description of the man from NHS England
25 hassling people on the phone about their targets. That
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1 doesn't seem to me to necessarily engender a great
2 relationship between NHS England and the hospitals or
3 the GPs, whoever it is. I mean, is that a reasonable
4 inference to draw from your description?

5 **A.** Yes, I just think it makes the whole system
6 very short term and makes it means it's continually
7 running hot and we need a system where things like
8 culture are able to be thought of in the way that
9 I think happens in other hospitals in other countries.
10 I don't want to over-exaggerate and I think in some ways
11 having one or two targets is absolutely fine.

12 **LADY JUSTICE THIRLWALL:** I understand that, yes.

13 **A.** That allows for people to focus on addressing
14 a national objective that an elected politician wants.
15 But I think it's gone too far in the system that we have
16 at the moment.

17 **LADY JUSTICE THIRLWALL:** Thank you. Then going
18 back to the other point that you were making and that
19 again is something we heard about from Sir Gordon
20 Messenger yesterday, these almost universal complaints
21 that the centre is pumping out endless directions so
22 they end up with so many priorities they can't
23 prioritise or don't prioritise anything, and one of the
24 academics, Professor Dixon-Woods, described it as
25 a "priority thicket" which was a very vivid description.

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1 looked at all of these and these -- these five in terms
2 of my missive to you this month are things that it would
3 be good to do if you can. They are positive things that
4 will make a difference.

5 But this one you really must do within the next
6 30 days because it doesn't cost any money and it's going
7 to save lives and I don't think anyone is thinking that
8 way and I think it's just basic management that when it
9 comes to clinical practice and things that would save
10 lives, we don't have a way at the moment, if there was
11 a different way of delivering a baby that was proven to
12 save lives and we should change to it straight away, we
13 don't really seem to have a way of making that happen.

14 **LADY JUSTICE THIRLWALL:** Yes. So what I was asking
15 you though, who would be the person or the people who
16 would carry out that work?

17 **A.** I think it should be under the direction of
18 the Medical Director for NHS England, Sir Stephen Powis,
19 that would be my -- he would be the right person.
20 I think he would understand and be able to make
21 a judgement as to how much it was reasonable to ask
22 Medical Directors to do on a monthly basis in terms of
23 improving safety and quality.

24 **LADY JUSTICE THIRLWALL:** I was rather hoping you
25 would say him because he is giving evidence next week.

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1 Now, I think your suggestion is that there should
2 be -- is it a group of people sort of who would then
3 advise Medical Directors in particular, you know, these
4 are the things that you ought to be -- where would those
5 people be drawn from?

6 **A.** So just to be clear. I am, I am talking about
7 clinical practice.

8 **LADY JUSTICE THIRLWALL:** Yes.

9 **A.** And my perspective has always been the
10 reduction of medical error. So this could well be
11 a structure or an approach that is important in other
12 elements of NHS management.

13 **LADY JUSTICE THIRLWALL:** You are talking about for
14 Medical Directors, aren't you?

15 **A.** But I am talking about what doctors and nurses
16 do at the coalface when they are looking after patients
17 and I think that the person that is responsible for them
18 in hospitals is the Medical Director and I think we
19 should be thinking what is a reasonable amount of things
20 that one can ask a busy Medical Director to change on
21 a monthly or annual basis. And then someone at the
22 centre needs to be saying: look, we have had these
23 recommendation from the Royal College of Paediatricians
24 and we have had this recommendation from the Francis
25 Inquiry and this recommendation from HSSIB and I have

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1 **A.** He may totally disagree, by the way.

2 **LADY JUSTICE THIRLWALL:** He may do.

3 Those are all my questions. Does anybody want to
4 ask anything arising out of those? No. I'm sorry we
5 have kept you a bit longer than we promised but not too
6 long. Thank you very much indeed, Mr Hunt, you are free
7 to go.

8 **A.** Thank you, my Lady, thank you, Ms Langdale.

9 **LADY JUSTICE THIRLWALL:** So that concludes the
10 evidence for this week?

11 **MS LANGDALE:** That's right, my Lady.

12 **LADY JUSTICE THIRLWALL:** And I think we are sitting
13 next Monday aren't we?

14 **MS LANGDALE:** We are, 10 o'clock.

15 **LADY JUSTICE THIRLWALL:** 10 o'clock next Monday.

16 Thank you very much all very much. See you next
17 Monday.

18 **(4.45 pm)**

19 (The Inquiry adjourned until 10.00 am
20 on Monday, 13 January 2025)

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