Witness Name: Dame Linda Pollard
Statement No.:LP/1
Exhibits: 8
Dated:21st February 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF Dame Linda Pollard

I, Dame Linda Pollard, will say as follows: -

1.1 As you can see from the attached CV, I have 30 years' experience as a Non-Executive in the NHS and 28 of those years as a Chair and have worked across several delivery arms of the NHS, but most of the experience at Trust Board level is within the acute provider sector whilst at the same time having a diverse private sector career Exhibit LP/1 INQ0017266 I have been a government advisor across different administrations, a variety of government Departments and managed restructures and change.

1.2 I was asked by the Secretary of State in 2021 to co-Chair the Messenger Review which subsequently led to Chairing the NHS England (NHSE) Management and Leadership Advisory Group (MALAG) whose work is ongoing. More information is set out in responses to questions 7 & 8.

2.1 Having Chaired several NHS Trusts my standard practice and views have not changed, but I have experienced several system changes steered by relevant administrations that I have adapted to, in order to adhere to the directives, set out to comply with national policy and regulators. My insight and reflections are based on my ethos of continued learning but fundamentally the NHS is a people business, be this staff or patients, and we need to listen and learn.

2.2 I have been Chair at Leeds Teaching Hospitals NHS Trust (LTHT) since February 2013. As an example, LTHT is a not a FT, therefore Chair and Non-Executive Director (NED) appointments are made via the Secretary of State, with a process delivered by NHS England (NHSE), formally NHS Improvement (NHSI) and prior to this the Training and Development Authority (TDA).

2.3 It is NHSE that would govern these appointment processes, setting the terms, conditions and remuneration. Chairs work with their Reginal Office and they will define who should constitute the interview panel, for both Chairs and CEO's, which normally consists of an NHSE Regional Director, ICB Chair/CEO and Chair/CEO of another Trust, and the incumbent Chair.

2.4 It is within my gift as the Chair of LTHT to define the skill set of the NEDs within the Board, as this should support the delivery of the Trust's Vision and Strategy. So, for example at the time of my appointment, LTHT was a failing Trust and was classified under special measures by the TDA, with a history of year-on-year deficit. At this point in time, it was appropriate for three of the NEDs within my Board to hold accountancy qualifications with skills gained from large commercial organisations that would help support the scrutiny and delivery of financial turnaround. Moving forward, with a number of years of financial balance and delivery of a surplus, the skill set of NEDs with financial background was no longer a key driver to underpin our Strategy. The Trust vision was for the re-development of the Leeds General Infirmary (LGI) a Victorian aged building unfit for patient care with over £100m of maintenance backlog, hence my desire to recruit a NED with Board level experience of construction accountability and delivery to support our vision for the site's re-development and now inclusion within the Hospitals of the Future build programme.

2.5 The NHSE advert for NEDs vacancies can be misleading to members of the local community as this is often mis-understood as 'lay representation', hence such adverts bring a number of inappropriate applications. At LTHT I always aim to appoint candidates with relevant skills and experience for the role (clearly stated in the advert) and will often use a head-hunting agency that precedes the NHSE advertisement process, to ensure that there is a good calibre of candidates to follow through the application process.

2.6 At LTHT we also support NHSE and others in their development programmes for encouraging future NEDs, which in affect helps with a training programme with the aim to build greater diversity within NHS Boards (which is a wider commitment beyond my own Board).

2.7 There are more FTs within the NHS than non-FTs, who operate a very different and disperse appointment process for Chairs and NEDs. Legislation in 2004 created FTs with the establishment of Governors, with a duty to appoint and remove the Chair and NEDs along with setting the terms and conditions and renumeration, (in addition to ratification of the appointment of the Chief Executive). This has played out in many ways. For example, NHSE tried to address the disparity of the remuneration with the publication

INQ0017267 Exhibit LP/2 (Provider Chair & NED Remuneration Structure 2019). However, there was no cost-of-living increase built into this for non-FTs, with FTs addressing this annually, hence the disparity grows once again.

2.8 A second example, that I watch with interest, is the recruitment processes for Chairs and NEDs within FTs. The interpretation of the duties/roles of Governors are played out with a range of practices. This could range from the observation of the named lead Governor within an interview panel, through to this process being at the 'beck and call' of the desires of the Governors (who by definition the majority are lay representatives of the local community, often without commercial skills) with in some cases five or six Governors at the interview process.

2.9 I also have concerns about Chairs who hold post in more than one Trust, however I do support a group model of Trust governance.

2.10 I support the changes in year from the publication of the Code of Governance that define a term of office for a NED routinely to be six years, as in keeping with corporate governance within the private sector, however for larger NHS organisations I do believe it is harder to commence Chairing a Trust with no previous NED or NHS experience.

2.11 As stated in the Review a full induction programme is essential, not only locally to understand your own Trust but I routinely ensure that my NEDs attend NHS Providers and Institute of Directors NED and Chair training and development, especially for Chairing Assurance Committees of the Board. It is essential that induction enables complete understanding of how the sector works nationally regionally and locally.

3.1 The Board governance mechanisms are set out and defined in rules and for LTHT these are within Standing Orders, Standing Financial Instructions (as a non-FT). This defines any delegation of some duties to formal Assurance Committees of the Board, that carry out these duties on of the Board behalf. These are defined in Committee Terms of Reference, cited within Standing Orders. Some duties e.g. complaints and mortality, (following previous national inquiries are required to be reported in the Public Board meeting and cannot be delegated), however deeper dives for assurance can be gained through Assurance Committees and reported to the Board. Therefore, having an Assurance Committee structure, reporting to Board, constituted with some Board members, Chaired by NEDs (independent lens as opposed to operational management), should be helpful for deeper scrutiny and guard against group think by the collective Board. It is for each NHS Trust to define the governance structures of their

Board, i.e. its Assurance Committees, noting the only formal requirement within the NHS is that of an Audit and Rem/Nomination Committee.

3.2 The question is not about the system, it's about the interpretation by the Board, the understanding of their duties and processes that are in place for escalation or assurance. The question is, how do the Board seek assurance and triangulation to understand patient safety within their own organisation, with what information, be this written reports, underpinned with data, versus walking the shop floor to really understand from the front line from both staff and patients. I would also raise at this point the critical role of the Company Secretary and within their role to ensure the accurate reporting of the most recent data to the Board and relevant Assurance Committees, triangulation and escalation between, which provides the foundations to good corporate governance.

3.3 A few years ago, I provided feedback to NHSE regarding the use of NED Board Champions, as this was becoming routine practice for NHSE to keep creating such roles but contradicts the concept of corporate governance via a unitary Board. We welcomed the publication of Exhibit LP/3 (Enhancing Board Oversight a New Approach to NED INQ0017265 Champion Roles) as the full Board must seek assurance and not delegate to one individual as a named 'Champion' however six roles remain as these are cited in legislation. One of which is the Maternity Safety Champion that I would strongly consider should be reviewed, as this one named Lead must be questioned for its role and purpose within a unitary Board. It is the full Board with equal accountability or culpability that are required to be assured of the safety of maternity services, which is underpinned by an assurance Committee of the Board ie for LTHT this would be the Quality Assuarnce Committee, Chaired by a Non-Executive Director reporting assurance or escalation back to Board, hence I do not support why this is defined and separated as a role with this title of Maternity Safety Champion.

3.4 Data reported to the Board at LTHT is set out using Statistical Process Control (SPC) to understand 'real' trends of the data held by the Trust. NB many Trusts may still RAG rate performance metrics – e.g. rate a target and its performance red, amber, green. Hence a constitutional target may be set at compliance of 95% but at Trust would only rate this as green when complaint. The threshold of rating at amber and red may be set by the Board or the Executive and can be misleading and can vary ratings in each report. Hence the need for data to be presented in SPC to really understand trends, over time periods and variances defined within tolerance thresholds set by the Board. Data must be benchmarked to understand trends with peers, and it is important to understand where the Trusts data is validated, which could be through internal audits or external review. A

Board must seek credible assurance *'to guard against marking its own homework'* and understand where and why it is an outlier, what action it is proposing to take to understand this, investigate, triangulate and monitor carefully that the action plan is actually delivering change or refined with further action that needs to be taken. Selection of peers can be an interesting choice and can be different group for difference services, eg A&E with Trauma Services, or Maternity Services with a regional remit/flow to Cardiac services for Neonates, versus national ranking against constitutional standards.

3.5 The Trust is required to collect and report many forms of data that underpins patient safety. How this is triangulated and used by the Assurance Committees of the Board is a fundamental question. Data and metrics reported to LTHT Board is set out within Exhibit INQ0017269 LP/4(Integrated Quality Performance Report (IQPR)) but there is a huge industry in collecting and presenting data to the Board and its Assurance Committees – eg mortality, complaints, serious incidents and never events, health & safety, staff survey, sickness and turn over, productivity vs finance, guardians of safe working and freedom to speak up are to name but a few.

3.6 The culture of the Trust is set by the Board and needs to be really 'lived' throughout the organisation. There must be understanding and wide acceptance of the transparency of safety of calling out mistakes, or speaking up, this must be accepted as custom and practice but with positivity, with wider understanding that the organisation wants to learn from any mistakes. Examples of how this messaging is set and delivered from the Board is via the Chief Executive giving his message each week within Corporate Induction in person – to engage all staff. In addition, staff over band 7 have an additional requirement to their induction, where they collectively attend the Executive Team meeting to hear first-hand the culture of the Trust and Leeds Way Values directly, and these staff are encouraged as incoming senior leaders to understand these values and their role model as new leaders within our organisation.

3.7 High staff engagement and data from the annual staff survey should be use by the Board as a valuable data set that provides insight to staff morale, and valuable feedback to triangulate for safety indicators. Local pulse surveys between the annual survey can be of value too. How does the Board track progress for improvement in its staff survey and with what mechanisms for targeted areas of improvement be this service areas or corporate themes.

3.8 Those who do the work, should be encouraged to improve the work. At LTHT we have an improvement methodology understood by all staff across the organisation, that is

based on the model from the Virginia Mason Institute, USA. How do organisations create a culture for safety and quality improvement is the big question.

3.9 The Board at LTHT in our triangulation need to test out what we hear in reports within Assurance Committees and the Board, we need to walk the shop floor which is through unannounced Leadership Walk Rounds, which is routine practice – see it, touch it, feel it ourself.

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3.10 The Board at LTHT have a mature Exhibit LP/5 (Risk Management Framework) that is led by the Chief Executive through a Risk Management Committee that meets monthly and reports to Board. This process sets out the strategic risks and mitigations within our Board Assurance Framework and the current operational risks set out in the Corporate Risk Register. The risks with the scores over 15 (5x5 metrics likelihood x severity) are reported to the Board. The Board have also defined our risk appetite thresholds that are set out in Exhibit LP/6 (the report template for all reports to our Board and Committees).

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3.11 The Board at LTHT operates on no surprises, this culture and practice is set between the working relationship between myself, as Chair and the Chief Executive, but also between any of the Executives and NEDs, within Board or Committee meetings and in any preparation for meetings, or where something needs escalating between these meetings or reported to the actual meeting/s. Ultimately this is underpinned by trust and confidence. Myself, Chief Executive, Chair of an Assurance Committee, or the full Board would request a self-imposed external review if we had concerns, and seek a second opinion. We would also make no hesitation to call in Regulators early. The culture within our Board would be that this was a positive action, that we were seeking assurance through a new/different lens and advice to steer a different course of action, so we were not blinded by group think.

3.12 One of the functions of our Assurance Committees, is to carry out deep dives on behalf of the Board to seek assurance or escalation. However, it is critical that the skills of the NEDs and Chairs of these Committees can probe and challenge appropriately, but also senior managers have the knowledge and understanding of corporate governance with skills to author quality reports that can either provide assurance or escalation. It's also essential for good triangulation between Committees, eg the Finance & Performance Committee seeks assurance of the delivery of activity defined in trajectories and will escalate to the Quality Assurance Committee to review safety, issues and potential harm if waiting lists are growing. Each of our Board and Committee meetings start with patient or staff story, some of these are positive, some are negative, but the purpose is to ground the start of our meetings, decisions are about real patients/staff.

3.13 Each year the Trust sets out a report against the required NHSE template, for the requirements of the Trusts Quality Account. This describes and demonstrates delivery or progress of your organisational priorities. The Board are held to account for this, as this is published each June and forms part of the yearend reporting processes within the AGM.

3.14. The Chief Executive is the Accountable Officer of the Trust and within the Annual Governance Statement, which is also part of the yearend process, has to set out the system of internal control (set template issued by NHSE) which asks that Trust explain what have been the in-year risks and challenges and the completed return is submitted to NHSE as the Regulator. If mortality and issues around neonatal services were a concern to LTHT, we would include statements within this but would qualify what and how the Trust was aiming to address any such issues.

4.1 Within LTHT, mortality with quarterly reports along with Summary Hospital-level Mortality Indictor (SHMI) and Hospital Standardised Mortality Ratios (HSMR), and incidents are reviewed by deep dives in the Quality Assurance Committee (QAC) with assurance or escalation set out in in the Committee Chairs report to Board. The quarterly Mortality Report received in this Committee will be provided for Board to support this report in the public domain.

4.2 Complaints and PALs data is reported to QAC for a deeper dive and flows to Board (as cannot delegate to a Committee) for the Annual report in July and six monthly update in January. Trends by service area are set out within these reports.

4.3 Safe staffing report (nursing and midwifery) is reviewed at Board twice a year with bimonthly reports to the QAC (and flow via Chairs report to Board), which is presented by the Director of Midwifery. Where this data is not within tolerance, then this will be explained with further context in the report and supporting action set out to state what action has/is to take place or why this is a concern.

4.4 Workforce data on sickness and turnover is reviewed by the Workforce Committee with a summary of the assurance or escalation as required to the Board set out in the Committee Chairs report to the Board.

4.5 The Board cannot delegate Freedom to Speak Up (FTSU) to a Committee, this is reported to Board with the annual report in (May) and six month update (Nov) by the FTSU Guardian.

4.6 Examples of the reports cited about can be found within the following link to the public Board papers of LTHT Board Meetings (leedsth.nhs.uk)

5.1 The Board have a vital role in defining the organisation values, ideally this should be underpinned by a wide staff engagement process to truly create ownership across the Trust. The values underpin the culture of the organisation and from the Board to ward staff should be encouraged to uphold the values. The Board are role models and all communication from face-to-face contact, to weekly Chief Executive bulletins, appraisals and staff celebration events should underpin the culture.

5.2 LTHT is an organisation with over 22,000 staff and 78 wards across seven sites, its large and complex. We have a delegated and accountable structure with 19 Clinical Service Units in addition to corporate functions. It is not the role of the Board to micromanage the organisation but have confidence in the processes and systems in place that provide a structure of governance, sitting alongside an open culture of reporting when things are not within benchmarked data or tolerances set by the Board, that escalation will take place. External validation, including those of regulatory bodies, internal and external audit are helpful objective opinions are valuable triangulation to be use by the Board.

5.3 The Board should adhere to the requirements of the CQC Well-Led criteria as a basic tool for assessing governance and highlighting areas required for improvement. This is also reinforced with the recent publication of the Code of Governance by NHSE.

5.4 In a large organisation there is always work to do to promote the role of and work of the FTSU Guardian, demonstrating the benefits of an organisation that strives to encourage speaking up but also demonstrates the ability to listen to its staff when raising a concern. We use staff stories relating to FTSU both at Board and within our Workforce Committee along with examples within the Chief Executives weekly email message to all staff 'My Week'

5.5 Within LTHT we work hard to ensure our governance structures support the Board with the information, escalation or assurance of issues relating to patient safety. The Executive Team through their Accountability Framework oversee the operational management of the CSU structures.

5.6 Twice a year our Board meet with the Tri Team Leadership of the 19 CSUs and the Deputy Directors within corporate functions, which equates to approximately 150 staff. This is an opportunity for the Board to listen and learn from our Senior Leaders, but also to touch and feel the culture of our Senior Leaders.

5.7 At each Board meeting we operate a 'Lunch and Learn' session, where smaller groups of the Board go out to visit new services or developments, or areas that are/have experienced significant pressure.

5.8 I personally walk the walk, I do not sit in Trust HQ, I work hard at being visible across our seven sites. My fundamental principle in life is that you need to earn the respect of staff you are not given this. In addition, I find it of immense value to stand in line with our staff in Costa Coffee or one of the other Retail Outlets or Staff Areas and just simple chat with staff – its amazing what you find out ! I also operate an open-door policy and staff can directly email me.

6.1 Given my position as Co-Chair of the Management and Leadership Group (MALAG) for NHSE working to implement the recommendation of the Messenger Review published 8 June 2022 some progress has been made towards implementing some recommendation. Since the work was commissioned and the recommendations were accepted there have been numerous changes to Secretary of State, however all have supported the recommendations and the work towards implementation has continued INQ0017272 with Exhibit LP/7 (the four year road map) sitting within the NHSE People Plan June 2023. Exhibit LP/8 (The Terms of Refence for Management and Leadership Advisory INQ0017273 Group) are supplied as supporting information for the remit of the implementation. Implementation of the now three-year plan will depend on capacity and resource within NHSE. We are now in year two of the four plan where the bulk of the work has to be done, and this will be wholly dependent on capacity and resource within NHSE.

7.1 The Messenger Review was completed in June 2022 and implementation must be set into the backdrop of political changes of Secretaries of State.

7.2 The Review was commissioned by Matt Hancock and the recommendations were accepted and agreed and we were to move to an Implementation Board, chaired by myself and populated by senior staff of the Department, senior NHSE staff and others as deemed helpful. When Sajid Javid took the reins (June 2021) he also agreed to an Implementation Board however before this was set up, we then moved to Steve Barclay (July 2022) and because of the delay, MALAG was designed to help with the work already being carried out within NHSE and the People Plan.

7.3 This is an ADVISORY group and not implementation and is administered by NHSE. We held our last meeting in October 2023. We advised on the four-year plan (Exhibit LP/7)

and year one (2023) was mostly a planning year with a few points of implementation, but the bulk of the delivery is in years two and three.

7.4 I do have concerns as to implementation due to the amount of work that needs to be done, whilst NHSE itself has just completed its own staff restructure and going forward I think there will be both capacity and revenue challenges.

7.5 The managers within the service deserve the move to professionally recognised standards and accreditations as in many other sectors, as in the recommendations of the Review, and there never has been a more acute time for staff to be supported.

7.6 Changes to Trust Board appointment, development, appraisal and reviews needs immediate implementation as the service is dealing with structural changes with the introduction of Integrated Care Boards (ICB's) and ICB Collaboratives and many are now working in a Group model or Trust mergers. These large organisations need very experienced Non-Exec's whose skill sets match the requirements of equivalent FTSE 100 companies. The differential between Foundation Trusts (FTs) and non-FTs still exists, but in particular the Governor role in many FTs where the final decision for the appointment of the CEO/Chair can be challenged or overturned by the Council of Governors.

8.1 My concluding comments and reflections are that sadly there have been a number of Trusts over the years that fail patient with safety, quality and duty of candour to the population they serve. The system provides reports and recommendations, regulators negatively rate Trusts, which drives poor staff morale, along with recruitment and retention issues. But what does the system do to truly support such Trusts and hold others to account for improving culture and values as this is the fundamental route course of poor quality and safety issues. I question management regulation that is currently debated and offered as a potential solution. Regulation of managers is a complex issue. The definition of a manager, including already regulated Clinicians/Nurses etc, is already there. Regulation needs to be in the context of the Messenger Review recommendations. When this issue was discussed at MALAG there was a helpful response from NHS Providers (CEO Julian Hartley) which could be obtained.

8.2 The right people need to be selected as Chairs and NEDs, with the drive to establish culture and values that engage staff. I do hold concerns about the current purpose of FTs and the of Governors, especially in the selection and appointment process of the

Chair, NEDs and appointment of the Chief Executive. It is widely perceived that this is an out-of-date model not fit for purpose but would require legislation to make any changes and would require Parliamentary time to address this.

8.3 I am hugely reliant on the role of the Company Secretary. In simple terms, this functions as the conscience of the Board, with adherence to the rules of wide corporate governance and those of the Trust, be this Standing Orders of a Committee's Terms of Reference. The neutrality of this role as neither an Executive or Non-Executive but whom should hold the respect of the Board and have the ability to call out and steer the governance. This is not present in all Trusts. I would also reflect that the role of the Senior Independent Director holds a valuable function as where do other Board members turn if they feel the CE and Chair are not listening, or not addressing the right things.

Supporting Reference material (documents supplied)

INQ0017266 (1) Exhibit LP/1 (CV)

INQ0017267 (2) Exhibit LP/2 (Provider Chair & NED Remuneration Structure 2019)

INQ0017265 (3) Exhibit LP/3 (B0994 Enhancing-board-oversight-a-new-approach-to-non-executive-director-champion-roles December-2021.pdf (england.nhs.uk)

INQ0017269 (4) Exhibit LP/4 (Integrated Quality Performance Report (IQPR) – example supplied from January 2024 public Board meeting)

INQ0017270 (5) Exhibit LP/5 (Risk Appetite March 2024 (second edition))

INQ0017271 (6) Exhibit LP/6 (Template Report for Board and Committee reports at LTHT)

INQ0017272 (7) Exhibit LP/7 (Four Year Road Map)

INQ0017273 (8) Exhibit LP/8 (Terms of Reference for MALAG)

Statement of Truth

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

Signed: Personal Data

Dated: 27/03/2024