Witness Name: Sir Gordon Messenger
Statement No.: 1
Exhibits: N/A
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THIRLWALL INQUIRY

WITNESS STATEMENT OF SIR GORDON MESSENGER

I, Sir Gordon Messenger, will say as follows: -

1. The Chair of the Inquiry has invited me to prepare a statement regarding my observations on the effectiveness of the culture, governance, management structures and processes, regulation and other external scrutiny in ensuring patient safety and quality of care. My credentials to comment stem almost entirely from my co-leadership of the Government-sponsored study into leadership and management in the healthcare and social care sectors, which led to the production of the independent report Leadership for a Collaborative and Inclusive Future, published in June 2022 (colloquially now referred to as the Messenger Review). Other contributing factors to my relevance include a 36-year career in the Royal Marines, culminating as Vice Chief of Defence Staff in 2019, and my ongoing membership of the UK Health Security Agency Advisory Board.

2. I should start with two caveats. Firstly, my in-depth experience with the NHS lasted only 8 months and concentrated almost exclusively on culture, leadership, management, personal development, behaviours and the importance of team building. I have no background in the operational or clinical aspects of healthcare. Secondly, our Study did not examine specifically the issue of baby safety and care. Therefore, my comments concern the impact on broader patient safety and care, although there is clear relevance for those people and systems responsible for babies.

3. Key Judgement. The central relevant judgement of the "Leadership for a Collaborative and Inclusive Future" Report was that investment in workforce culture, values, development, collaboration, leadership and teamwork has, over time, been unwisely de-prioritised against the backdrop of well-documented operational and external pressures. This too often generates tensions and behaviours in the workplace which, exacerbated by engrained status and professional stovepipes, leads too frequently to an absence of instinctive teamwork and collective ownership of problems. If workers feel unsupported and alone, either by colleagues or by the system more broadly, they will make decisions

accordingly. The results can be a widespread blame culture (which itself dissipates the likelihood of real wrongdoing being exposed) or the avoidance of shouldering any collective responsibility, ie simply coming to work and doing no more than obligated. By no means universal but common enough to call out, these behaviours are not restricted to any band or profession within the NHS and are as prevalent among the higher-skilled clinical cohorts.

4. Leadership. The most effective way to counter such instincts is to create a team culture where people feel valued, invested in, and collectively responsible for both the good and bad regardless of their role, status, or skill level. This can only be achieved by strong leadership at all levels. And yet investment in leadership in the NHS is patchy, overly focused on senior bands, and too dependent on individual motivations than on organisational norms. In my view, there is an inadequate leadership component within initial medical, nursing and management training, despite a perceived gap of effective team building at the coalface, and through-career leadership development is too often an under-appreciated afterthought rather than considered an essential element of organisational success and talent management. This generic observation may not appear to be pertinent to an Inquiry such as this but, in my view, it is central to the matter in hand.

5. Collaboration. Accountability is unfortunately more easily measured and judged when viewed in the vertical, through the outputs of a single sector, organisation, or business unit. But remarkably few health outcomes are delivered in such stovepipes as most rely upon effective working across boundaries, be they sectoral (eg healthcare and social care, primary and secondary healthcare), organisational (eg between Trusts, or even ward to ward), professional (eg between specialisations and professions, clinicians and managers) or cultural and status-driven (which transcend all of the above). Focusing on singular, vertical accountability can drive system-wide inefficiencies, regional and inter-Trust inequity, rife issues of trust in the workplace, and counter-productive leadership behaviours. If accountability could be elevated to cover the realities of cross-boundary outcomes, with overall patient care and safety and pan-sectoral efficiency as the key metrics, we would be in a happier place. If properly supported, the emergent role of ICBs should prove a turning-point in this regard.

6. Board Governance. I do not feel sufficiently well-qualified to comment on whether the current Board governance model is the right one for the NHS, although I would argue that a tighter definition of a Board's responsibilities and accountabilities should be a central feature of the ongoing NHS work on its new operating model. I would also add:

- the differentiated governance arrangements for Foundation Trusts appear anachronistic, prone to uncollaborative practice, and difficult to justify.
- The Messenger Review referred specifically to the selection procedure for non-executive directors and strongly recommended a more systematic approach to their selection and diversity. Recommendation 6 of the report goes into more detail.

7. Senior Leadership. In my view, too much attention is spent on the individuality, singular accountability, and behaviours of senior NHS leaders, and not enough on the feeder system that institutionally develops and selects them. The delegation of senior selection responsibility to external Executive Search companies is a clear symptom of the absence of a sufficiently effective, in-house, through-career system for personal development and talent management. Chief Executives, both the good and the bad, ascend in a manner that is inadequately mandated by a system which is currently too dependent upon patronage, individual instinct, external input, and happenstance.

8. Developing Leadership Talent. This sub-optimal approach is not the fault of individuals within the system, but of a disinvestment over time in foundational workforce development tools which are arguably second nature in some sectors, ie leadership training and support, career development, talent management, effective use of appraisals. While some of these shortcomings are more pertinent within the managerial cohort, the inadequacy of the leadership component in an NHS career is true for all professions:

    - Given the high proportion of clinicians in senior management roles, the insufficiency of institutional leadership (and management) training and development in our medical and clinical professions is stark. This is true of both entry-level and their through-career syllabi. Roles such as Clinical Director, Medical Director and Nursing Director must increasingly be seen as prestigious, launchpad opportunities rather than poisoned chalices which distract from professional credibility. If one's kudos and value are derived less from one's surgical expertise (still very important, of course) and more from one's impact on broader collective improvement, a wholly positive team ethos should naturally emerge. Esteemed organisations such as the GMC, NMC and the Royal Colleges should do more to ensure this is the case.
    - The career and talent management of NHS managers is inadequately structured and valued by the system that employs them, and I would observe they can collectively suffer from status and identity issues as a result. Required skills and

competencies are currently overly delegated to individuals and Trusts when the benefits of a centrally stipulated framework are both clear and much sought after by those involved. Too frequently, the development of future leaders is based upon their personal motivation rather than a consistent, programmatic approach to up-skilling. The selection, cultivation and promotion of talent is woefully random, with little systemic assurance that the right people are making it to the top and with a potentially negative impact on diversity and inclusion among senior leaders. Recommendations 3, 4 and 5 of the Messenger Review offer structured thoughts on how to address this issue.

9. Regulation of Managers. The growing instinct to regulate NHS managers is no doubt born of the vagaries of the system described above. But I would argue that such a step may be unnecessary if an appropriately structured and consistent system-wide approach to professional competencies, career support and talent management is embraced. Essentially, the assurance benefits of regulation would be met, yet without the accompanying bureaucratic and resource overhead. Moreover, some of the potentially negative implications of regulation (eg obstacle to lateral entry, the perception of it as a purely punitive tool, yet another regulatory layer on an already bureaucracy-laden workforce, overhead costs) could be avoided.

10. Conclusion. Without knowing the detail of the specific incidents which the Inquiry is mandated to examine, my commentary is necessarily generic although I would argue no less important. My short time with the NHS revealed to me a very purposeful and patient-centric workforce which over time has suffered from under-investment and which, as a result of ongoing and historical internal and external pressures, can struggle to maintain the instinctively collaborative and team-driven culture which is at the heart of organisational excellence. I would add two notes of caution:

    - Adding even more regulatory and statutory demands into the NHS workplace would add to the pressures expressed above.
    - NHS managers are often unfairly depicted as the source of the problem. The reality is that they are as hard-working, talented, patient driven, and motivated as any other part of the workforce. However, because they can suffer from a lack of professional recognition and status compared to their clinical and medical colleagues, they can be convenient scapegoats when things go wrong.

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: 28 March 2024