Witness Name: Sir Andrew Morris
Statement No.: 1
Exhibits: see exhibit list
Dated: 05/03/2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF SIR ANDREW MORRIS

I, Sir Andrew Morris, OBE, Hon FRCP will say as follows: -

Background

1. I am a Non-Executive Director on the Board of NHS England. I joined the Board as joint-Deputy Chair on 1 July 2022.

2. I was previously Chair of NHS Improvement from October 2021 to June 2022, when it was abolished. I had been a Non-Executive Director on the Board of NHS Improvement since August 2018.

3. Prior to my NHS England roles, I was General Manager of Frimley Park Hospital NHS Foundation Trust, and then Chief Executive from 1991 to 2018. In 2014, as Chief Executive, I led the merger with Heatherwood and Wexham Park Hospitals NHS Foundation Trust to form Frimley Health NHS Foundation Trust.

4. I was Knighted in 2015 and made an honorary fellow of the Royal College of Physicians in 2016 for my contribution to healthcare management.

5. I am a Trustee of Disability Initiative, a charity providing disability services since 2017 and I became its Chair in 2022.

Culture, Governance and Management Structures

6. I have worked in the NHS for over 45 years and have been a Chief Executive at Trust level for over a quarter of a century. I have no doubt that the governance arrangements for Trusts and the drive to improve quality and patient experience has developed significantly, particularly over recent years, with the introduction of regulation and the Care Quality Commission inspection regime.

7. The post COVID-19 period has been the most challenging ever for the NHS. As a result, Trusts are facing unprecedented financial, service delivery and workforce pressures which has further heightened the need for strong and effective governance at Board level, particularly in relation to quality and patient safety. Trusts treat nearly half a million people a day and healthcare is an inherently risky business, so learning from mistakes and understanding and mitigating risk is a crucial part of any Board's agenda.

8. The starting point to understanding culture, governance and management within the NHS is that Trusts are separate legal entities, and Boards have responsibility for establishing effective governance and structures.

9. To support Boards with this responsibility, there is no shortage of guidance to Trusts on effective governance. Both NHS England and the Care Quality Commission have issued very comprehensive advice, such as the "NHS Code of Governance for NHS provider trusts" **[Exhibit AM/0001 [INQ0012647]],** and various guidance on the "Well Led" Framework i.e. "Well led framework for governance reviews: guidance for NHS Foundation Trusts" **[INQ0009237]**. If these are fully adopted by Boards, they should have the impact of improving the overall stewardship of resources, quality and safety, as well patient experience.

10. The new Patient Safety Incident Response Framework **[Exhibit INQ0009265]** should improve learning from incidents through its four key aims:

    a. Compassionate engagement and involvement of those affected by patient safety incidents.

    b. Application of a range of system-based approaches to learning from patient safety incidents.

    c. Considered and proportionate responses to patient safety incidents.

d. Supportive oversight focused on improvement.

11. This guidance should significantly enhance patient safety across the system.

Leadership and Culture

12. I believe that quality of leadership is probably the most important factor in an organisation's culture. How the Board sets the tone of the organisation is one of its major responsibilities. At the centre of this is the values and behaviours that it expects from everyone within the organisation. NHS England and the Department of Health and Social Care mandate to NHS organisations (via the NHS Constitution for England **[Exhibit AM/0002 [INQ0012646]]**) the key principles and core values of the NHS, which include:

a. To aspire to the highest standards of excellence and professionalism;

b. The patient is at the heart of everything the NHS does;

c. Respect and dignity;

d. Compassion;

e. Improving lives; and

f. Everyone counts.

13. Every Board needs to understand its own culture, foster patient centred working and have environments that support staff as set out in the "People Promise" **[Exhibit AM/0003 [INQ0012638]]**.

14. The Care Quality Commission "Well Led" Standard has reinforced the importance of Board leadership and effectiveness.

15. It is the Board's role to provide oversight of its organisation. How well it does this depends on how well Board members know their organisation. In my experience, helpful markers for this are:

a. How often do significant issues or concerns surface without any pre-warning appear on a Board's agenda that you have not been alerted to beforehand?

b. Is there openness and transparency about all aspects of the Trust's

business?

c. Are there strategies at Board and directorate level which make a difference to patient outcomes and experience?

16. In my opinion, organisations should be open and honest when things go wrong and take the following steps: undertaking preliminary investigation in a speedy manner; having a dialogue with those affected; where appropriate saying sorry in a meaningful way; and learning from events. Where care is delivered in a sub-standard way, Boards need to demonstrate humility and an openness to learning. Whilst reputation management has a place in any organisation, it should never trump the Duty of Candour when incidents occur.

Governance

17. In my experience, the vast majority of Trusts have a strong focus on continuing to develop good governance arrangements that have quality of care and patient safety at their heart. I would say that this is very different to the position 10 - 15 years ago, as Trusts now devote more board time to quality and patient safety. These improvements have been in areas such as understanding risk, having better quality information (by developing key quality markers, and getting data in a timely way), learning from incidents, promoting openness and transparency, and developing a "no blame" culture.

18. A typical Trust will have many external bodies and organisations regulating various aspects of its delivery of service or professional standards. Some of these many bodies regulating Trusts use inconsistent definitions and data sets which create added complexity for Trusts in interpretation and compliance. In my experience, there is a need to rationalise data definitions and harmonise standards used for assessment across these bodies. This is because when looking at patient outcomes, it is important to make sure you are comparing like for like. If different data definitions are being used to look at the same area, they can draw out different conclusions, which can be unhelpful and not represent the full picture.

19. I feel that caution is required in responding to events with further governance and regulation. There has in the past been a tendency to respond to each inquiry in a longitudinal manner, simply adding more requirements and more oversight agencies. Trusts can be overwhelmed by what appears to be competing demands from different regulators, and some form of rationalisation is required.

Structure of the NHS

20. Around the turn of the century, there was the establishment of the internal market and competition between providers, which had the unintended consequence of fragmenting care pathways for patients. The internal market and competition also heightened the importance of reputation management which sometimes led to reputation management having priority over openness and transparency for patients.

21. In 2023, NHS England established 42 Integrated Care Boards to replace over 100 Clinical Commissioning Groups with the aim of better integrating care in geographical localities and introduced a duty on providers to collaborate rather than compete. This recent major structural change towards Integrated Care Boards should be allowed to be embedded as it should bring significant benefits to the quality of services. Therefore, in my view, a further major structural change is not required because the move to Integrated Care Boards has fostered a new approach of encouraging the collective leadership in a locality to work beyond their own organisational boundaries to develop new models of care, which over time will further improve patient outcomes and experience.

22. Historically, NHS Foundation Trusts have benefited from having greater freedoms than NHS Trusts to manage their affairs, although over time some of these freedoms, especially in relation to finance and capital have been scaled back, NHS Foundation Trusts can still determine their own rates of pay. At some point in the future, I believe that the Government should consider unifying these freedoms across both types of Trust.

The Three-Year Plan for Maternity and Neonatal Services

23. Following the Ockenden review **[Exhibit AM/0004 [INQ0012641]]**[1] and Kirkup report[2] **[Exhibit AM/0005 [INQ0012366]]**, NHS England issued its Three-Year Delivery Plan for Maternity and Neonatal Services **[Exhibit AM/0006 [INQ0012643]]** which was published in March 2023 (the Three-Year Plan). I am NHS England's non-executive lead for maternity services, and I believe that the Three-Year Plan is one of the most comprehensive governance plans that NHS England has ever issued for a specific

[1] An independent maternity review led by senior registered midwife Donna Ockenden: "Ockenden Report – Final: findings, conclusions and essential actions from the Ockenden review of maternity services at Shrewsbury and Telford Hospital NHS Trust," 30 March 2022.
[2] The Report of the independent investigation led by Dr Bill Kirkup: "Maternity and neonatal services in East Kent: 'Reading the signals" report" 19 October 2022.

service. This covers all aspects of governance, workforce, patient safety, patient experience and stakeholder involvement. The Three-Year Plan brings together the learning from previous reviews of maternity and neonatal services and provides actions for Trusts to implement. It focuses on four key themes:

a. Listening to and working with women and families with compassion.

b. Growing, retaining, and supporting our workforce.

c. Developing and sustaining a culture of safety, learning, and support.

d. Standards and structures that underpin safer, more personalised, and more equitable care.

24. The Three-Year Plan also includes increasing the numbers of midwives and neonatal nurses to be trained under the workforce plan **[Exhibit AM/0007 [INQ0012644]]** in response to known demographic changes in the workforce.

25. Over £ **I&S** has been invested to deliver the Three-Year Plan since 2022 and I, along with other NHS England Non-Executive Directors, have championed the need for this additional funding which was sourced from existing NHS funds. The Government declined to allocate new funding.

26. The rollout of the Federated Data Platform[3] and access to real time outcome data will enhance the safety of maternity and neonatal services, but this relies on a separate funding stream.

27. The establishment of twenty Integrated Care Boards for neonatal services will take effect from April 2024, which will enhance oversight of all services including maternity, foetal medicine, neonatal services, maternity and neonatal transport, and perinatal pathology. Over £ **I&S** is being invested in staff and additional cot capacity.

28. NHS England expects every Trust to implement the Three-Year Plan and Boards have a responsibility to ensure delivery. The NHS England Board will review progress periodically.

[3] The Federated Data Platform (FDP) is software that will sit across NHS trusts and integrated care systems allowing them to connect data they already hold in a secure and safe environment (NHS England » Data platform frequently asked questions)

Doctors and Managers' Work in Managing Patient Safety

29. Clinical engagement and leadership are essential for the effective management of a Trust. The Board has a responsibility to establish and foster structures that place clinicians at the heart of quality improvement and patient safety. Management structures vary from Trust to Trust but crucially all specialties should have a voice and input to all aspects of Trust management. In the Trust I led, all specialties were represented at the Operational Board by ten clinical Chiefs of Service reporting directly to the Chief Executive. Obstetrics / Maternity, and Paediatrics (including neonatal care) each had their own Chief of Service on the Operational Board which lifted the profile of these important services.

30. I believe that it is important to have clinicians in management positions, in part because clinicians know their service best, so are well placed to take ownership of changes needed within their specialism. I also think that this helps to create a sense of identity and pride in the organisation.

31. Within each division, I found that it was important to have:

    a. Clarity around objectives: at Frimley Health, every Chief of Service had a clear set of objectives, and the directorate needs a collective drive and delegated authority to deliver those objectives.

    b. Governance and safety aspects reflected in the objectives of each directorate

    c. The right infrastructure to support decision making within the directorate, including the importance of timely information.

    d. A performance dashboard that each directorate would have and develop, which would feed up to the Trust-wide quality committee that a Non-Executive Director would chair for challenge and scrutiny.

    e. Groups and committees reflecting patient and staff concerns e.g., a patient experience group, and an audit and safety committee.

32. At Frimley Health, we had a template for Chiefs of Service to feed back issues to the main Board, and they would take it in turns to present to the Board a performance dashboard. This meant that they had direct access to all Board members in an open forum for raising issues.

33. In my experience, clinicians are passionate about the services they provide, but require accurate information and protected time to address issues. It is paramount to promote the role of safety champion for each specialty, with appropriate support, to establish effective patient pathways and develop a responsive safety culture. Learning from and responding to incidents along with a "no blame" culture are characteristics the Board must lead and support. The development of Clinical Networks on a multi-Trust basis enables a further level of scrutiny of quality standards, audit and safety.

34. In order for doctors and managers (whether clinical or non-clinical, and whether within the division or at Board level) to work well together, trust is significant factor. I found that having clinicians in management positions and having stability at management and Board level helped to promote that trust. At Frimley Health, each Chief of Service had a development programme, and we had a leadership programme for anyone wanting to progress to managerial roles. The Board and senior managers were always focussed on succession planning and developing existing talent within the organisation. A number of ward sisters progressed through the organisation into Board roles. Progressing people through the organisation helps to develop a team ethos of doing the best for patient care, and having shared goals to improve and learn. Promoting people within an organisation creates a high level of managerial stability and organisational memory, but this should be in parallel to recruiting talent from outside the organisation.

35. At national level, the NHS Leadership Academy sits within the Workforce, Training and Education Directorate of NHS England. It was established in 2012 and its principal purpose is the stewardship of the leadership agenda including developing outstanding leadership in health with a continual focus on improving the experiences and health outcomes of patients. The Faculty of Medical Leadership and Management was established by all the UK medical royal colleges and endorsed by the Academy of Medical Royal Colleges 10 years ago, in recognition of the importance of effective medical leadership and the impact this has on patient care. Its aim is to create a body promoting the recruitment and development of doctors and dentists wishing to be actively involved in healthcare leadership. These two support programmes and organisations help clinicians to progress in healthcare leadership and management and the number of clinicians wishing to contribute to management functions in the NHS is increasing.

Freedom to Speak Up

36. Freedom to Speak Up has improved the culture of the NHS. It exists in addition to the normal mechanisms of how staff interface with the organisation in raising concerns and should not replace effective management.

37. Each Trust has a Freedom to Speak Up Non-Executive Director champion on its Board. They should act as an independent voice and at Board level they should champion those who raise concerns. They should work closely with the Freedom to Speak Up Guardians (who support staff to speak up under the Freedom to Speak Up policy) and act as a conduit to share information between staff (via the Freedom to Speak Up Guardian), managers, and the Board.

38. In my experience, the Chief Executive of a Trust is particularly influential in setting the tone of speaking up, which helps to remove any barriers to speaking up that people might otherwise perceive. Chief Executives should create an environment where Freedom to Speak Up guardians have open access to the Board and operate in an environment where all managers are seen to listen and act on issues when they are raised. A Board should establish a tone of openness by having a visible presence, seeking feedback from all levels within the organisation, and when things go wrong, they should ensure that managers listen and act. Sending a clear signal from the Board and senior managers that no detriment will result from speaking up should be a central tenet of a Trust's values, but in my view, this is not communicated strongly enough in many organisations.

39. There is an expectation that Trust Boards will respond and suitably deal with all Freedom to Speak Up matters, however one area of improvement is better communication to staff of what to do in exceptional circumstances if they have a very serious concern regarding safety and they feel that their organisation is not addressing the issue adequately. I feel that communication in this area needs to be strengthened so that people know what their alternative avenues are e.g., the Care Quality Commission, their own professional bodies (such as the GMC or NMC), or NHS England. I am Co-Chair of a working group looking at this issue, involving the Care Quality Commission, National Guardian's Office and professional bodies. In addition, the group is exploring ways of enhancing Freedom to Speak Up in General Practice, in conjunction with Integrated Care Boards.

40. The National Guardian's Office oversees the training of Freedom to Speak Up guardians and offers a comprehensive package to support them. There are over 1,000 Freedom to Speak Up guardians working in the NHS and independent sector.

41. In my role as NHS England's Non-Executive Director Champion for Speaking Up, I believe that Freedom to Speak Up is making a difference, but in some organisations, further improvement and refinement is required. Implementation of the scheme can also vary widely across organisations, for example:

    a. Not every Freedom to Speak Up guardian has an open invite to the Board through the Freedom to Speak up Non-Executive Director champion.

    b. There should be more training for managers on how to deal with speaking up as some managers do not realise the importance of listening and acting.

    c. Freedom to Speak Up could be incorporated into appraisals at all levels of the organisation.

Trust Management Structures

Executive and Non-Executive Directors

42. A Trust is its own legal entity within a federated system, and the Board is its controlling mind. The Chief Executive is the accountable officer and is supported by the rest of the team, comprising both executive and Non-Executive Directors. I believe that the principle of Trusts having a unitary Board, with both executive and Non-Executive Directors is successful, as the Non-Executive Directors enhance the effectiveness of the overall Board. The Non-Executive Directors are independent, act as a critical friend to the Board, and hold the Board to account. The emphasis on scrutiny by the Non-Executive Directors has increased substantially in recent years, particularly in relation to quality and safety.

43. In my experience, organisations that develop better outcomes for patients are those with high staff engagement, flatter management structures, clear lines of accountability, well-understood values and standards of behaviour, and objectives driven by the constant ambition to provide the very best care.

44. The Chief Executive is the accountable officer of a Trust. The "NHS Foundation Trust accounting officer memorandum" **[Exhibit AM/0008 [INQ0012636]]** is unambiguous in that the Chief Executive is accountable for all aspects of the organisation's

performance and governance. However, it is important to also have stability, and I think that any new Chief Executive or manager needs to be given time to implement the changes required, particularly in relation to culture as it is not something that can be achieved instantly.

45. An effective Board needs a mix of skills with a variety of experiences, for example banking, business, HR and legal, both from within the NHS and recruited externally. This range of experiences adds value to the business of any Board, and in the NHS, this needs to be balanced by people who understand the work of clinicians. Having a cadre of expertise that you can draw on from Non-Executive Directors is important. Some Boards only have one clinical Non-Executive Director but given the increasing need to for scrutiny and focus on quality and patient safety, there is a case to increase this to a minimum of two clinical Non-Executive Directors on each Board. Also, there is the option to appoint associate Non-Executive Directors with clinical backgrounds to help with the management of the quality and patient safety agenda.

46. The NHS needs to further increase the pipeline of potential Chairs and Non-Executive Directors, and I know that NHS England is keen to do that by promoting these roles more widely, such as through the Academy, as set out above.

47. Historically, Non-Executive Director remuneration in NHS Trusts has lagged behind those within NHS Foundation Trusts so there is merit in having single rate of pay for all Trusts and remunerating appropriately for time given above the expected two to three days per month commitment. This would also encourage interest from a wider group of people.

48. All Non-Executive Directors should be given adequate training on their role by NHS England. This is so that Non-Executive Directors get up to speed around how the NHS works, its culture, key issues that NHS Boards should be addressing, and preparing the Non-Executive Directors to add maximum value to an NHS Board.

49. Various further pieces of guidance will be issued by NHS England, such as:

    a. The Insightful Board

    b. The Board-level Leadership Competency Framework

    c. A Board-level Appraisal Framework

    d. A Board-level Induction Framework for New Chairs and Non-Executive

Directors

50. I understand that each of these will be covered in more detail within the statement provided to the Inquiry by NHS England.

Non-Executive Champion / Lead Roles.

51. Non-Executive Directors often have "lead" roles on the Board. For example, a Non-Executive Director will typically chair a quality committee which will also have an overview of patient safety and patient experience, although some organisations have separate leads for each of these aspects.

52. In 2021, I led (with the input of several Trust Chairs) a review of the non-executive roles at Trust level. The review was needed because Trusts were finding that Non-Executive Directors were being asked to "lead" on too many different areas. "Enhancing Board Oversight: A new approach to Non-Executive Director champion roles" **[Exhibit AM/0009 [INQ0012640]]** was published in December 2021, which identified five non-executive champion roles which would be retained, including Freedom to Speak Up, a Wellbeing Guardian, and Maternity Board Safety Champion (including obstetric, midwifery and neonatal care). By moving the remaining lead Non-Executive Director roles to a committee structure led mainly by executive directors, it enabled the five retained Non-Executive Director roles to focus on the five retained roles.

53. The Maternity Board Safety Champions have been effective in promoting change in most neonatal and maternity services, working with the relevant teams as a "critical friend" and helping to ensure that improvements are implemented. They act as a conduit between the Board and front-line safety champions (obstetric, midwifery and neonatal care), service users, local maternity systems, the regional midwife and lead obstetricians, and they chair quality and safety committees for maternity and neonatal services. They are key in making the Three-Year Plan a central piece of business for every NHS Board in England. They make sure that relevant information is visible to the Board by highlighting Key Performance Indicators, having oversight of the action plan that every Trust is required to have for maternity, setting the standards of consultant and senior midwife cover, and generally bringing any issues to the Board such as clinical performance and workforce.

54. In the same way that Trust Boards have a Maternity Board Safety Champion, I am the non-executive lead for maternity on the NHS England Board. In carrying out this

role, I have work closely with Dame Ruth May, Chief Nursing Officer on the NHS England Executive Board to promote safety and ensure maternity and neonatal services are on high on our agenda.

NHS Foundation Trust Governors

55. NHS Foundation Trusts (such as Frimley Health) have governors who are there to scrutinise the Board and should be in regular dialogue with the Board. Governors have responsibility for appointing the Chair of the Board for NHS Foundation Trusts. The impact and input that governors have in relation to governance varies across NHS Foundation Trusts. At Frimley Health, governors contributed to the quality and safety committees, and to the development of patient engagement and patient experience strategies. On Board walkabouts, governors were invited and had the opportunity to hear directly from staff. Whenever any significant issues or concerns arose, we always made sure that the governors were aware and that we shared with them the action plans for resolving particular issues. In my experience, governors provide additional scrutiny of Board performance from the point of view of local representation, as they are people voted in by members. Overall, I found them to be a helpful critical friend.

Recruitment and Selection of Managers

56. It is important for an organisation to recruit the right people at every level of the organisation, both clinically and managerially, and these people need to demonstrate that they share the values of the organisation. In all instances, senior managers at Trusts should be recruited according to the values and behaviours of the organisation, as set out by the Board. Chief Executive appointments should have appropriately qualified panels including an external assessor, with the involvement of the regional director. The selection processes are generally robust. However, NHS England should further review support offered to Chief Executive/Executive Directors who take on organisations that are particularly challenged. The Recovery Support Programme managed by NHS England is effective and well developed but a stronger focus is required to identify additional suitably experienced people to take on significantly challenged organisations.

57. Trusts should be recruiting according to the values and behaviours, and competency frameworks. There are specific competency frameworks in place for Chairs and Chief Executive appointments.

58. NHS England will be issuing guidance on the appointment process for Chairs and Non-Executive Directors, which will include advice on diversity, open competition, appointment panels, tenure, multiple appointments, and the removal or suspension from office for Chairs of Integrated Care Boards and Trusts.

Regulation of Managers

59. The Kark review of the Fit and Proper Person test in 2019 **[Exhibit AM0010 [INQ0012637]]** made seven recommendations regarding the fit and proper person framework. NHS England and NHS Improvement considered each recommendation. On 14 July 2021, I wrote to the Minister of State at the Department of Health and Social Care, on behalf of NHS England and NHS Improvement, setting out our agreement that five of the recommendations should be implemented **[Exhibit AM/0011 [INQ0012639]].** One of the remaining recommendations related to social care, which was beyond the remit of NHS England. For the other remaining recommendation, namely to "disbar for serious misconduct" we considered that a suitable alternative would be to extend the referencing approach to capture misconduct to avoid re-employment within the NHS. We considered this to be a similar deterrent and less costly to the taxpayer. Later that year, the then Secretary of State replied supporting the actions taken by NHS England and requesting a review in 2025 **[Exhibit AM/0012 [INQ0012642]].**

60. In August 2023, NHS England published a revised Fit and Proper Person Framework **[Exhibit AM/0013 [INQ0012645]]**, which brings additional background checks and includes an annual refresh and attestation of fitness. The Framework is designed to assess the appropriateness of an individual to discharge their duties effectively in their capacity as a Board member. The Framework will help Board members build a portfolio to support and provide assurance that they are fit and proper, while demonstrably unfit Board members will be prevented from moving between NHS organisations.

61. I can see the benefits of independent regulation for senior NHS managers in the same way that other professions are regulated. If there is to be full regulation of senior managers, i.e., beyond the extended referencing approach, there are various considerations that will need to be considered, such as the cost to the taxpayer: would the cost of formal regulation come from additional public money, or from existing NHS funds, and therefore potentially impact on other services. In my view, the current arrangement is cost effective and addresses the key concern of preventing people

from moving around the NHS who should not be in senior positions. In my opinion, current arrangements should be allowed to bed in and then be reviewed before a final decision on whether full regulation is required. If full formal regulation for senior managers is implemented, it is my belief that NHS England should not act as the regulator. It should be an arm's length organisation that would be accrediting and regulating senior NHS managers. Most regulators are completely separate from the organisations they regulate, such as financial services, doctors, nurses, lawyers.

Provision of Information to Trust Boards and to NHS England

62. A Trust Board should be receiving the following information regarding patient or staff concerns:

    a. An analysis of complaints and learning arising from key issues identified.

    b. Patient experience reports

    c. Incident trend information, events of major concern, and the learning from them.

    d. Feedback from PALS (Patient Advice and Liaison Service)

    e. Staff surveys

    f. Workforce data, including grievances, sickness, turnover, and other HR metrics.

    g. Clinical outcomes and benchmarking

    h. Progress on implementing the NHS People Promise

    i. Risk register actions

    j. Reports from regulators i.e., Care Quality Commission, NHS England, Healthcare Safety Investigation Branch

    k. Findings of any major external patient safety quality reviews.

63. The findings of any Trust commissioned external and independent patient safety and quality reviews should be shared with Integrated Care Boards. In my view, this should be consistent practice.

64. A key learning point from previous inquiries and guidance has been for a Board to challenge whether the information it uses to govern the organisation is accurate and effective. There is an NHS England programme of work to develop effective, active governance, namely that appropriate issues are considered by the right people, the relevant information is reviewed in the most useful format at the right time, and the level of scrutiny produces rigorous challenge and an effective response. There is draft guidance under current development, titled "the Insightful Board."

65. Beyond data and reports, I think that a vital aspect of information gathering for Boards is ward level walkabouts. At Frimley Health, Board members, including myself, would spend time in different areas of the hospitals. I found that you could learn a great deal from hearing what patients had to say about the service, and this created a very useful form of first-hand intelligence, beyond the normal repertoire of data and reports. Hospital walkabouts were therefore a very important conduit in connecting the hospital floor to the Board, ensuring patients' views were fed into the Board in terms of our thinking when setting the strategy regarding patient outcomes and experience. I always encouraged the Non-Executive Directors and the NHS Foundation Trust governors to walk about and talk to staff and patients.

66. NHS England should be advised by Trust Boards and / or ICBs of very serious whistleblowing matters, significant issues flagged by the Care Quality Commission or Healthcare Safety Investigation Branch, any updates from the Recovery Support Programme (previously known as Special Measures), the output from any nationally commissioned inquiries, and the findings of any Trust commissioned external and independent patient safety and quality reviews.

67. It is important to note that the NHS England Board has a structure of sub-committees to develop policy and strategies for consideration, and review performance. The NHS England Board has a very extensive and wide-ranging set of responsibilities which can only be effectively discharged through the use of sub-committees. Therefore, the matters listed above would initially be notified to an executive director of the NHS England Board, and then considered by a committee where appropriate. If necessary, it would also be flagged to the whole Board.

Statement of Truth

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: 5th March 2024