Witness Name: Nick Hulme
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THIRLWALL INQUIRY

WITNESS STATEMENT OF NICK HULME

I, Nick Hulme, Chief Executive Officer ("**CEO**") of East Suffolk and North Essex NHS Foundation Trust ("**ESNEFT**") and Norfolk and Norwich University Hospital NHS Foundation Trust ("**NNUH**") will say as follows: -

Introduction

1. I have over 40 years of experience in health and social care gained in multi-site acute and community settings, and over 13 years Chief Executive experience in the NHS. I am currently the CEO of ESNEFT. Additionally, on an interim basis until 4 March 2024, I am also the CEO of NNUH.

2. By way of background, ESNEFT was formed through a merger between Ipswich and Colchester Hospitals. I was appointed as CEO of Ipswich Hospital in January 2013, following their disappointing Care Quality Commission ("**CQC**") report and when the Trust was failing to meet standards. After three years of success in achieving standards and delivery on the financial control total, the Trust acquired community services in Suffolk; from May 2016 I served concurrently as CEO of Colchester Hospital, which was rated inadequate by the CQC and had been placed in Special Measures for four years. Within one year of appointment I led the organisation out of Special Measures and delivered the merger with Ipswich Hospital in 2018 to form ESNEFT.

3. Between October 2021 and January 2022 I was the National Lead for the 12 to 15 years cohort of the Covid Vaccination Programme, which involved regular planning and feedback sessions with senior officers across government, politicians and the Prime Minister's office.

4. I was appointed as the interim CEO of NNUH in August 2023, a role I hold alongside my role as CEO at ESNEFT. I will continue to hold this additional CEO role until 4 March 2024, when the substantive incumbent commences in role and at which point I will return

'full-time' to ESNEFT. At the present time I work with c20,000 staff.

5. I am also an elected Board member of NHS Providers, which represents NHS Trusts throughout England and I regularly provide interviews to local and national media on health and care issues.

6. Prior to joining what has now become ESNEFT, between 2002 and 2012 I worked in a range of NHS Trusts at Executive leadership level. This included CEO of Croydon Health Services NHS Trust between 2009 and 2012, Chief Operating Officer and Deputy CEO of Buckinghamshire Hospitals between 2007 and 2009, Executive Director of Operations / Deputy CEO at North West London Hospitals ("**NWLHs**") between 2005 and 2007 and Executive Director of Operations at NWLHs between 2002 and 2005.

7. Between 2001 and 2012 I was an elected Trustee of the Terrance Higgins Trust, and for the final two years I was elected Chairman of the Trust.

8. Prior to this, during the 1990s I undertook a range of roles within the NHS, including working as a Health Advisor between 1990 and 1992. I started my first management role within the NHS in 1992, prior to being appointed to senior leadership roles in operational and general management. I completed my Master of Business Administration in 1999.

9. The views expressed within this statement are based on my personal experience gained through the roles I have undertaken, and whilst I do have several years of experience at senior leadership level, I am only able to base my answers on this, rather than the NHS as a whole. The experience of CEOs in other NHS organisations may be considerably different, although there will also be similarities.

10. This statement is structured as follows:

    A. Effectiveness of the culture, governance and management structures in the NHS to ensure the quality of care and to keep patients safe
    B. Conflicts between staff
    C. Management and Leadership
    D. Freedom to Speak Up
    E. Effectiveness of Organisational Governance
    F. Appointment to Senior Roles

G. Accountability of Senior Managers

A. Effectiveness of the culture, governance and management structures in the NHS to ensure the quality of care and to keep patients safe

11. The effectiveness of governance and management structures varies from one organisation to another. Culture, governance and management structures complement each other in ensuring quality of care and keeping patients safe. Culture is developed over time, and through experience. Governance is in part defined through legislation and by regulators and in part developed through good practice being documented and followed, management structures are based on the requirements of individual organisations. The effectiveness of management varies dependent on experience and training: recruitment, training and development is crucial, as is investment in conflict resolution and mediation.

12. In my experience, clinicians often undertake leadership roles with little or no formal leadership training or leadership preparation. This makes it difficult for individuals to know how to act when concerns are escalated to them – therefore training of managers, clinical and non-clinical, is essential.

13. Addressing the barriers to speaking up – which exist in all organisations – through training and raising awareness is essential. It is vital that leaders have an understanding of their workforce and empathy for those who are least heard.

14. Balancing the need to act when concerns are raised with the need to ensure these concerns are well founded is a potential area of concern. Ensuring access to independent oversight of any raising concerns process including Freedom to Speak Up, is crucial to effectively navigating this challenge, but even bringing externality and independence, is not infallible.

15. Effective managers are key to delivering effective care to our patients and I recognise that increasingly the requirements to deliver on stretching targets whilst also delivering efficiency savings are extraordinarily challenging, and are compounded further by the need and desire to reduce waiting times for our population.

16. In my view, the greatest risk to patient safety currently is the unacceptable waits for services provided; waiting times for cancer treatment, elective care and emergency care are far too long, despite the best efforts of staff, which in turn impacts on morale and culture.

B. Conflicts between staff

17. Some commentators make a distinction between clinicians and managers, and suggest that conflicts between the two are inherent. I find this distinction as an arbitrary division unhelpful: most managers come from a clinical background. That being said, there is benefit in having both clinical and non-clinical managers as they can bring a different perspective. There can be potential conflicts between professional groups. In my experience, often clinicians can find it difficult to look beyond the patient in front of them, as they see the clinical need, rather than the wider risk amongst patients within the waiting room / community – which non-clinical managers often raise.

18. Given the number of people working within NHS provider organisations, it is likely that from time to time people fall out with each other and there will be conflict. Within ESNEFT we employ over 12,000 people. There is a close working relationship between doctors and both clinical and non-clinical managers, with a number of multi-disciplinary meetings allowing discussion of issues and concerns.

19. I welcome colleagues speaking up, offering their view and raising challenges: I do not see conflict as always being negative; there are examples where to achieve the best possible patient outcomes it is in fact, necessary. Welcoming a range of views, particularly in highly complex scenarios, which include emotive issues as is often the case in supporting patients; is helpful and when managed well, results in improved patient care and patient safety.

20. On occasions where conflicts escalate, as they do in all work places, then it is important to have the correct processes in place to deal with this; for example through offers of facilitation or mediation, or in more extreme cases, following the processes outlined in bullying and harassment, civility and respect policies and toolkits, or even grievance and disciplinary processes.

21. When conflict escalates or problems emerge; these are seldom a surprise. Previous concerns may either have not met a threshold for escalation or there are multiple and

complex issues lying beneath what initially manifests itself as a single issue. On occasion it may also be the case that previous attempts to ameliorate the issue(s) at an earlier stage have failed. Clinical and non-clinical managers need the skills, experience and expertise to manage highly complex issues and recognise when they need help to resolve.

22. The importance of giving confidence to raise issues; to triangulate and provide resolution is critical to safe patient care. Furthermore; often those in executive management are transient; unlike long term appointments such as consultants; and therefore improving and supporting the leadership capacity and capability of clinical and non-clinical managers is vital.

Improving relationships

23. To improve relationships amongst all staff, building a collaborative culture is essential. This can be encouraged through supporting staff to train and learn together, for example providing junior doctors with induction and training opportunities alongside middle manager colleagues. Effectively using apprenticeships can also support this; for example supporting trainees to spend time within different departments to learn about different aspects of the organisation; including spending times with the patient safety teams and Patient Advice and Liaison Service ("**PALS**"), participating in after action reviews.

24. These approaches reduce hierarchy gradient, remove potential defensiveness and support an open culture in which staff are more confident to speak up. Improvements in the availability of expertise and usage of mediation and facilitation is also very important in identifying and supporting the efficient and effective repair of relationships.

25. Recognition that cultural issues within teams can result in a lack of trust and reduced confidence / efficacy in speaking up is also essential. The use of coaching / organisational development support; embedding this within departments and actively working with teams makes a significant difference to staff confidence in raising concerns, feeding back actions and, as a result, improving patient outcomes.

26. Thinking specifically about the impacts of conflicts between staff on neonatal units, in my experience, neonatal units are no more or less complicated than anywhere else - I have not experienced particular issues in the context of the safety of babies on neonatal units,

and in my experience relationships in specialist units tend to be better than those in other areas.

27. Within the neonatal unit at ESNEFT, we support quadumvirate teams (of obstetricians, midwives, neonatal clinicians and managers) from both sites in attending the Perinatal Culture and Leadership Development Programme. This was developed nationally in response to the recommendations from the Ockenden review and aims to provide maternity leaders with the knowledge and skills to improve workplace culture and facilitate improved collaborative working between obstetricians, midwives, neonatal clinicians and managers: teams from both ESNEFT sites formed part of the first cohort for this programme.

C. Management and Leadership

28. Reflecting on changes to medical management over the last ten years, I would conclude that this has improved somewhat. However, there remains, as the Messenger Review (see Exhibit NH/1) put it, "complex inter-professional and status issues" which impact on behavioural cultures. In the context of this inquiry, I would perhaps offer that this is more easily recognisable as the hierarchy gradient and the potential impact this may have on speaking up, silencing quieter voices, and ultimately posing a barrier to raising concerns.

29. One of the key changes is the greater recognition of the role clinical leaders have in setting the tone and standards of behaviour. This creates culture, which is key. There has been a move away from co-opted leadership roles for doctors, and a move towards professionalisation of medical leadership roles with adequate training and preparation – which is essential. Regrettably, although improvements are evident, there remains inadequacy in the way medical leadership (indeed potentially all leadership) is trained.

30. At ESNEFT we have invested in leadership development and offer a range of accredited training programmes aimed at all levels of staff within the organisation, recognising the benefits that this brings to our patients. Within these programmes clinical and non-clinical leaders learn together, reducing barriers to communication and improving networking - cultivating a culture of open communication and support.

31. Better recognition of the role both medical and non-medical management play in the delivery of safe, effective and efficient care is crucial – at both an organisational and national level. Many commentators on the NHS often criticise managers within health and care organisations, in my view not always fairly. This can be extremely unhelpful, impacting morale and ultimately service delivery.

32. Leadership and management skills need to be seen as the basic building blocks of organisational success, and given sufficient priority. It is vital that there is continued, increased investment in developing clinical leadership community, providing opportunity to develop leadership skills in a supportive and networked environment. I fully support the recommendations within the Messenger Review (see Exhibit NH/1) with regard to establishing consistent universal standards for management and leadership training.

33. I would also highlight the critical importance of improving diversity. It is still too difficult for colleagues from ethnic minority backgrounds to progress to leadership roles; which reduces the ability of the NHS to hear and address concerns.

34. Further investment in governance, including risk management and crucially patient voice around their experience is really important in supporting management and leadership development.

35. Alongside this, recognition and appropriate action to address the demand placed on all staff to deliver health and care services within the context of the current system pressures would be extremely beneficial.

D. **Freedom to Speak Up**

36. In my experience, the Freedom to Speak Up ("**FTSU**") Guardians system is effective in providing staff at all levels with the ability to raise concerns openly, or anonymously if preferred, to somebody independent and outside of their direct work area. I recognise however that the FTSU system itself is dependent on staff being aware of it and having the confidence to use it.

37. Undoubtedly, freedom to speak up initiatives have helped to improve the culture within the NHS, through encouraging those who have concerns to raise them. A nationally consistent message is also helpful. The national and local messages and activities that

support these are also essential in turning a policy message into reality.

38. FTSU initiatives encourage staff to highlight issues, to challenge the status quo or question the norm, as well as encourage learning. They support a patient safety culture, alongside incident reporting, PALS and complaints handling – all of which, when managed effectively, lead to learning, change and ultimately safer care and improved experience.

Barriers to speaking up

39. I recognised that there are significant challenges regarding the willingness of all staff to raise concerns. Staff at all levels may be inhibited from speaking up if they are scared of the impact it may have on them personally – for example on their reputation, career progression and/or relationship with colleagues, fear of jeopardising employment or residency status, language and cultural barriers. Staff may also feel that it is too risky to challenge the status quo or that nothing will happen so it is just not worth it. Barriers to speaking up tend to shift over time, and those with more experience or with greater seniority may feel more confident to speak up – but it is vital that we ensure that the voices of all staff are heard and encouraged.

40. I also recognise that nationally all NHS staff are operating under significant pressure trying to keep pace with the increased demand for services, which often results in unacceptable waits for the services we provide. This itself creates risks to patient safety and of course limits the capacity of managers and clinicians to address or escalate concerns if they are raised. This further inhibits health professionals from raising concerns in the first place.

Addressing the barriers to speaking up

41. Leaders have the responsibility to create the culture of openness and honesty in which all colleagues are able to raise concerns. This will not be achieved through one simple speak up message, campaign or policy. It needs to be embedded within the culture: there needs to be relevant protections for staff, they need to have the belief that they will be taken seriously (which is often established through seeing others raising concerns and action being taken), they must not be penalised, and where something is identified that is wrong or needs to be put right then they need to believe that the required change will be made. Truly listening is to hear the concern, take the relevant action and then,

where appropriate, communicating about it – being open about what has happened and what action has been taken.

42. And the culture needs to be nurtured, looked after, protected, developed: it is important that leadership encourage staff to highlight issues, to challenge the status quo or question the norm, as well as encourage learning – as this ultimately leads to safer care and improved experience.

43. Within ESNEFT we have recently held a Board development session with the national speak up guardian, have revised our FTSU policy and continued to work on awareness: we have introduced training for new managers, created new posters for staff and patients, increased the number of FTSU guardian assistants from 7 to 12 (with representation from our staff networks, and appropriate training) and are delivering a series of 'town hall' events to promote discussion with our senior leaders. Our training emphasises the many barriers to speaking up and encourages managers to take action to address these.

44. Establishing and promoting inclusive staff networks is an important part of encouraging confidence in speaking out and addressing inequalities. Within ESNEFT, our networks focus on bringing people who share a specific identity together with those who do not share that identify, creating conversation, inclusion and mutual understanding - amongst other benefits, these build a sense of community, provide peer support and help us to identify barriers and practices that may adversely affect our staff.

E. **Effectiveness of Organisational Governance**

45. Effective corporate governance and risk structures within the organisation are crucial to ensuring the relevant information is reported with the appropriate level of detail, and external regulatory review – including the CQC and independent well-led review processes - both triangulates and provide assurance around this.

46. The system of Boards made up of executive and non-executive directors ("**NEDs**") is an effective means of monitoring quality of care and overall safety of patients. In practice, the effectiveness of individual Boards is reliant on the governance systems and processes that feed it and the individuals appointed to the Board.

47. Semi-independent, external oversight, achieved through the use of NEDs providing appropriate scrutiny, is an effective method of holding the executive to account, and NEDs are a key part of the organisation's governance.

48. Whilst NHS Foundation Trusts are required to set out their governance in line with the Foundation Trust template constitution, implementations vary in effectiveness and there may be benefit in implementing a peer review process amongst provider organisations.

49. Within governance structures, providing routes to amplify the voices of staff, patients and their relatives/carers, to raise concerns and provide feedback is crucial, and consideration could be given to provider organisations establishing a patient/carer council.

50. Within ESNEFT, Board members hear directly from patients, carers and their families through patient stories. Additionally, formal patient experience reporting is provided to the Board via its sub-committees which receive an analysis of the themes arising from complaints, and cross cutting theme discussions. There are also several governance groups which facilitate interaction with patient groups on specific services, including maternity, and the leadership of the Trust (both Executive and Non-executive) regularly visit Trust sites to hear directly from service managers and service users.

51. We are also working on establishing a Carers' Council to offer a formal approach to carer involvement – to ensure that their collective voice is strengthened and reaches the heart of the organisation.

52. Thinking more specifically in relation to the safety of babies, national guidance regarding forums that operate across the system – for example the Local Maternity and Neonatal System ("**LMNS**"), Neonatal Networks and Integrated Care Board / Integrated Care System would be beneficial to ensure consistency and avoid any duplication.

F. **Appointment to Senior Roles**

Non-Executive Directors

53. The vast number of health and care organisations within England means that there is a limited pool from which to recruit non-executives. Furthermore, the level of remuneration is often not reflective of the experience sought to undertake the role nor the time commitment required – often relying on the goodwill of individuals. This means that it can be difficult to attract NEDs with the appropriate skillset and experience.

54. Key to NEDs performing effectively is appropriate induction and training. I agree with the recommendations of the Messenger Review (see Exhibit NH/1), regarding the effective recruitment and development of NEDs and consider this to be key to ensuring that healthcare organisations appropriately exercise their responsibilities.

55. The current NED appointment arrangements for NHS Foundation Trusts are that governors, elected from a potentially small electoral cohort, are those who appoint NEDs and the Chair of the Trust. In my view, this is increasingly inappropriate, given the size, scale and complexity of these organisations.

Chief Executive Officers and Senior Managers

56. Values based recruitment is critical as part of the criteria on which senior leadership roles should be based. Honesty; integrity; kindness; excellent communication; problem solving; motivation; optimism and the ability to appreciate contribution and undertake appreciative enquiry are all important skills which should be demonstrated as part of a selection process. There is naturally an importance of appropriate technical skills, but alongside those; managers require the aforementioned skills and abilities to perform effectively in their roles.

57. For senior managers, the selection processes could benefit from greater independence – including, for example introducing a patient panel and staff involvement. Decisions should be made using agreed transparent criteria.

58. The pipeline for future Chief Executives needs more investment to ensure that we make use of the very senior expertise we have. For CEOs, a national appointments process would be beneficial.

59. To reflect on my own experience; Trusts working in group models (examples exist in the Midlands and South regions) provide demonstrable evidence of the level of improvement that can be made with a highly expert, experienced executive and non-executive Board.

G. **Accountability of Senior Managers**

60. Managers within the NHS are doing a difficult job, many with accredited training, but often with little or no formal leadership preparation. Introducing professional regulation, with associated training and development, and access to expertise and support would be helpful and play a role in developing leaders and enhancing accountability. I agree with the recommendations within the Messenger Review (see Exhibit NH/1) regarding: standards and structures; a simplified, standard appraisal system for the NHS and; a new career and talent management function for managers in this regard. As noted by Messenger, "management within the NHS lacks the status enjoyed by the established professions", introducing universally applied standards to achieve agreed levels of behaviour and competence would address this. I also agree that this could be further enhanced through developing a formal accredited training curriculum for managers, with completion of the training becoming a pre-requisite to advancement to more senior roles.

61. The disadvantage of introducing professional regulation may come down to perception – and how it is portrayed by commentators; regulation will ultimately come with financial and time expense – and whilst I am supportive, questions will likely be asked as to whether the cost is worth the benefit.

Conclusion

62. I am grateful for the opportunity to provide my reflections on the impact of culture, governance and processes on patient safety. I recognise that there are always opportunities for improvement. However, in my opinion the greater risk to safety at the moment is that the NHS has come to accept what should be unacceptable in terms of the level of service we are able to provide in response to the demands placed on us. Regrettably, even with the best governance, training and culture, human nature being what

it is, mistakes can happen and we can miss things. This however should not discourage us from taking action to improve the safety and experience for our patients and staff: we should not hesitate to take the necessary actions.

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: _____ PD

Dated: _____06.02.2024 _____