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THIRLWALL INQUIRY

WITNESS STATEMENT OF PROFESSOR JUDITH SMITH
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I, Professor Judith Smith, will say as follows: -

1. I am Professor of Health Policy and Management at the Health Services Management Centre (HSMC) in the School of Social Policy and Society at the University of Birmingham, a post I have held since 2015. I am also Director of Health Services Research with Birmingham Health Partners, Trustee and Chair of Health Services Research UK, Visting Senior Fellow at the Health Foundation and Senior Associate of the Nuffield Trust.

2. I have worked in health services research, evaluation and development since 1995, following an earlier career as a senior manager in the NHS in Solihull and Coventry and having completed the NHS Graduate Management Training Scheme. My research and teaching focus on the organisation and management of primary and integrated care, evaluation of new models of care, healthcare management and organisational governance. I am co-author of one of the main international textbooks on health management (with Professor Kieran Walshe), and I have published extensively for practitioner, policy and academic audiences.

3. From 2015-2022 was I was the Director of HSMC and a member of the University's Leadership Forum. Prior to this I spent over six years as Director of Policy at the Nuffield Trust, a charitable independent health research foundation in London. From 1996 to 2009 I was employed by the University of Birmingham as a Fellow and then Senior Lecturer at HSMC, and from 2007-2009, was seconded on a research fellowship to the Health Services Research Centre of Victoria University of Wellington New Zealand and working as a part-time policy advisor in the New Zealand Ministry of Health.

4. From 2014-2022, I was a Non-Executive Director of Birmingham Women's and Children's NHS Foundation Trust, and from 2020 to 2024, Deputy Director of the Health and Social Care Delivery Research Programme of the National Institute for Health and Care Research. From 2010 to 2013 I was expert adviser on NHS organisation and commissioning to the Mid-Staffordshire NHS Foundation Trust Public Inquiry and an assessor of the inquiry's recommendations. In 2000 I prepared expert evidence (with Professor Chris Ham) on NHS management and culture for the Bristol Public Inquiry into paediatric cardiac surgery.

Thematic framework for my evidence

5. I have been asked by the Thirlwall Inquiry team to provide evidence on topics related to Section C of the Inquiry Terms of Reference. I use the following themes to organise my evidence:

   - Context and nature of NHS provider management and leadership.
   - Oversight and regulation of NHS management and leadership.
   - Leadership qualities and behaviours for senior NHS managers.
   - Training and development of NHS managers and leaders.
   - The role of NHS boards in quality and safety governance.
   - The critical yet complex role of culture.
   - Openness, speaking up, hearing and responding.
   - The reasons why inquiry recommendations work or not.
   - Conclusions.

Context and nature of NHS provider management and leadership

6. In this section, I set out the distinctive features of NHS management and leadership that I consider particularly pertinent to the topics in Section C of the Inquiry terms of reference.

7. **A centrally managed healthcare system**. The NHS is notable in the international context for being a particularly large-scale and centrally managed health care system where NHS England has responsibility for operational management of most of the service, sharing policy direction with the Department of Health and Social Care [1]. This contrasts with many equivalent high-income countries where typically the national ministry of health will set strategy, with much of the detail and oversight of

implementation left to the discretion of regional and local authorities and institutions. Policy analysis undertaken in 2022 for the NHS Confederation concluded that central oversight and performance management of the local NHS has increased over time despite various policy intentions towards greater local control [2]. A summary of current NHS management and accountability structures is available here [3]: NHS England » Structure of the NHS

8. Central oversight, targets and performance management can prove very useful when seeking to achieve improvements such as reductions in hospital-acquired infections or waiting times for treatment. One consequence however of this centralised nature of the health system is that NHS senior managers and boards are keenly aware that they have a particularly strong and close accountability to national politicians and policy makers, being inclined to look upwards for guidance and approval rather than outwards to the local community, or inwards to patients and staff [4].

9. A 'command and control' approach has been reported often to characterise the relationship between the policy centre and local NHS organisations [4] and this has been noted by previous public inquiries to sometimes lead to a culture of blame and fear on the part of local NHS leaders and boards [5]. This can create cultures and incentives whereby boards and managers are more vested in narratives of success and reputation management rather than open and honest communication to the public and the centre about problems and deficiencies. As problems are hidden this can prevent system learning and improvement [6].This may in turn contribute to reticence about speaking up about problems encountered by a local NHS organisation, its leaders instead tending towards 'a culture of self-promotion rather than critical analysis and openness' [5] (Francis, 2013, p44) or being what Dr Bill Kirkup described in his East Kent Hospitals NHS Foundation Trust Inquiry Report (p23) as a 'Trust [that] prioritised reputation management to the detriment of being open and straightforward with families, with regulators and with others [7].

10. The NHS, despite its overall centralised approach to policy and performance management, has always had a degree of local administrative discretion which creates variations between areas and organisations [8]. This can lead to what is sometimes termed a 'postcode lottery' where services delivered in one area are different to another in terms of quantity, quality, and safety [9]. This local variation and discretion are also reflected in what has been termed a rather 'federated' NHS management system [10] whereby national policy and guidance may be interpreted

and acted upon to differing extents locally. The NHS is therefore sometimes paradoxical in how its management operates – this local variation may indeed be something of a reaction to what might be perceived as undue national influence.

11. **An under-managed healthcare system**. Public and media perceptions often assert that the NHS has too many managers [11]. The number of people employed specifically as managers (51,000 in 2015, including doctors and nurses working full-time as managers) is however low in the context of the wider UK economy, being 4% of the NHS workforce as compared to 10% in the wider economy [11]. Professor Ian Kirkpatrick has undertaken research that similarly reported 3.5% of the NHS workforce as being managers [12] and that even marginal increases in the number of managers can lead to statistically significant improvements in the performance of NHS acute trusts, as measured by patient experience, reduced infection rates, and overall efficiency. Kirkpatrick and Malby [13] argued that the NHS needs more 'world class management' by lay and clinical leaders to address the challenges that it faces. It is important to note that with an under-managed health system and organisations, there are risks associated with people being over-stretched in their work, such as taking 'short cuts' [14] or otherwise 'gaming' the system [15].

12. **NHS trusts and foundation trusts**. In 1992, self-governing NHS trusts were introduced as part of the Conservative Government's market reforms of the NHS [16]. Trusts were given new freedoms to plan and organise their activity with less direction from district health authorities and were required to adopt a corporate board model of governance, with a chair, chief executive and a majority of non-executive directors drawn from industry or other areas of public life. The use of the corporate board model of governance of NHS provider organisations in England has endured for over 30 years. The board is at the apex of an NHS trust or foundation trust. Its chief executive is accountable to the trust chair and board of directors. The role and responsibilities of an NHS trust chair are set out in guidance from NHS England [17]. Relationships within a board, in particular between chair and chief executive and between executive and non-executive directors are considered vital to the effective functioning of the trust and its assurance of safe high-quality care [18]. Board roles, behaviours and effectiveness are explored further in the section of this statement on the role of NHS boards in quality and safety governance below.

13. In 2002, the Labour Government introduced the option of foundation trust status for NHS trusts whereby they would have more organisational independence, operating as a public benefit corporation [19]. Many trusts applied to assume foundation trust status but despite a range of cultural and organisational changes, the associated freedoms were not taken up as extensively as intended [20]. Strong implicit or explicit accountability to the policy and political centre continued to exert its influence, or as Nick Timmins put it 'behaviour trumps legislation' [21] (p49).

14. As a counterbalance to what were originally considered rather radical NHS reforms to the governance of local healthcare providers, foundation trusts are required to establish a council of governors. This is formed of 'members' of the NHS foundation trust who are patients of the trust and/or people living within the catchment area of the organisation who have opted to become trust members, along with members of staff. The governors have a formal role in scrutinising the performance of the trust, appointing and holding to account the chair and non-executive directors and signing off strategic plans [22].

15. **Clinical governance**. The governance of healthcare organisations is distinctive in needing always to combine organisational and financial performance with matters of care quality and safety, the latter being known as 'clinical governance'. Clinical governance was introduced into the NHS as a policy priority in 1997 [23] and defined in policy guidance by Scally and Donaldson [24] as:

    > 'A framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish'.

16. Clinical governance took shape in various ways including the creation of a care quality regulator (the Commission for Health Improvement, now the Care Quality Commission), the articulation of fundamental standards of care in the wake of the 2013 Francis Inquiry report, the requirement for NHS trusts to prepare annual Quality Accounts alongside financial accounts [25], and the designation of a formal responsibility for care quality and safety on the part of NHS trust boards in parallel to their financial and organisational accountability [26]. The ways in which the dual accountabilities of quality and safety, alongside finance and organisation, are managed at all levels of an NHS provider, from ward through to board, are the

essence of clinical governance. They were set out in policy guidance from DHSC [27] following the 2013 Francis Inquiry report and are overseen by the NHS England National Quality Board [28]. The intertwined nature of clinical and organisational/financial governance is part of the physiology of NHS providers, with managers and clinical leaders at all levels playing a key role in monitoring and assuring the quality and safety of services. The role of the trust board in operating effective clinical governance is explored in detail in paragraphs 72-97.

17. **'Hybrid' clinical managers and leaders**. Another distinctive feature of healthcare management and leadership is that many managers – at all levels of the organisation - are clinically qualified, often combining their leadership role with clinical work. Professor David Buchanan and colleagues [29] termed this group as 'hybrid managers', noting that they include roles such as clinical directors, ward managers, senior nurses and chief pharmacists. Analysis by Warwick Business School in 2018 estimated that a third of NHS managers were doctors or nurses working part-time in management roles [30].

18. The challenging nature of hybrid management roles was explored in research by Professor Huw Davies and Dr Alison Powell in 2002 [31] and 2016 [32], examining roles including the medical director and clinical director in acute NHS trusts. They emphasised the importance yet often frustrating nature of such roles, the variable quality of relationships between doctors and managers, the undermining nature of the poor public reputation of healthcare management, the lack of a national framework to define and support clinical director and other hybrid senior roles, and the need for more structured training (including mentoring) for people taking up these posts.

19. Dickinson and colleagues [33] reported on a study of medical leadership across the NHS and highlighted the existence of an 'engagement gap' in many instances between medical directors who were part of the trust board on the one hand and specialty leads and the general consultant body on the other. This underlined a potential clash of cultures between clinicians and managers and the complexity faced by a clinician becoming an executive director, which for some clinicians equates to moving to the 'dark side' [33]. This 'engagement gap' is something of which NHS trust boards need to be very mindful, assuring themselves that there is effective and

open engagement of clinicians and clinical leaders at all levels of the organisation, working in a way that supports clinical governance.

20. The importance for healthcare organisations of having effective and well-supported medical and broader clinical leadership has been emphasised by international experts [34, 35]. Sir Gordon Messenger and Dame Linda Pollard [36] noted in their review of NHS leadership in 2022 that: 'the medical profession does have a unique responsibility for leading behavioural change where necessary and supporting a positive culture within their sector where all staff flourish' while also drawing attention to 'the flawed assumption that simply acquiring seniority in a particular profession translates into leadership skills and knowledge'.

Oversight and regulation of NHS management and leadership

21. In this section I explore the debate about whether and how NHS managers and leaders might be regulated, including consideration of what a code of conduct might comprise and how it could be used.

22. **The debate about regulation of NHS managers**. It is 23 years since the Kennedy Inquiry report [37] called for more effective oversight of and support for senior NHS managers in carrying out their statutory duty for the protection of standards of patient care, and for consideration to be given to establishing a system of regulation of managers based on a formal code of conduct or ethics. Sir Ian Kennedy also proposed that managers be subject to formal continuing professional development (CPD), regular appraisal and revalidation. Debates about regulating NHS managers focus on the need for clearer accountability for their actions, and equity with clinical professionals who are subject to regulation through a code of practice [38].

23. Similar proposals were made by Lord Darzi in his 2008 Report 'Enhancing High Quality Care For All' [39], Ian Dalton in his 2010 report on assuring the quality of NHS senior managers [40], Sir Robert Francis KC in his 2013 report of the Mid-Staffordshire Inquiry [41], Sir Stuart Rose in his review of NHS leadership in 2015 [10], Sir Ron Kerr in his 2018 report on senior NHS executive leadership [4], and Sir Gordon Messenger and Dame Linda Pollard in their review of NHS leadership in 2022 [36]. Whilst the actual blend of proposed measures has varied, the need for formalised management standards and ethics, supported by regular compulsory

appraisal and CPD, and a register or database of managers to hold references and assure 'fitness to practise' have been a consistent feature.

24. **The Code of Conduct for NHS Managers**. Such calls have largely gone unheeded by politicians and NHS policy makers when responding to external reviews. One exception was the development of a Code of Conduct for NHS Managers as part of the government's response to the Bristol Inquiry, this being intended to form part of all senior managers' employment contracts [42]. This was led by Ken Jarrold (a former Head of HR for the NHS) and co-produced with NHS managers and when introduced was welcomed for its articulation of expected values, standards and behaviours. The principles underpinning the Code of Conduct for NHS Managers are set out in Box 1 below. Over time, the code appeared to lose whatever 'teeth' it might have been intended to have, with its use being at best voluntary within some NHS trusts. Ken Jarrold reflected his regret about this in an article in 2023 [43]:

> 'Sadly, although the code was adopted and NHS organisations were asked to incorporate it into the employment contracts of all senior managers, it was not promoted or enforced. If the code had been a living part of NHS culture, events at Stafford and Chester might have been very different.'

> As an NHS manager, I will observe the following principles:
>
> Make the care and safety of patients my first concern and act to protect them from risk.
>
> Respect the public, patients, relatives, carers, NHS staff and partners in other agencies.
>
> Be honest and act with integrity.
>
> Accept responsibility for my own work and the proper performance of the people I manage.
>
> Show my commitment to working as a team member by working with all my colleagues in the NHS and the wider community.
>
> Take responsibility for my own learning and development.
>
> *Box 1: Code of Conduct for NHS Managers (Department of Health, 2002)*

25. **The appointment, training and assurance of chairs and non-executive directors**. As explored in paragraphs 6-20 (Context) NHS bodies rely on collective leadership through the model of the corporate board comprised of executive and non-executive directors with the latter in the majority. It is therefore important that

any consideration of the regulation and oversight of NHS managers and leaders attends to non-executive directors and chairs, as well as to employed managers and leaders. Just as the Code of Conduct for NHS Managers fell out of consistent use, so the NHS Appointments Commission was abolished in 2012, this being the body that was previously responsible for the recruitment, appointment and oversight of NHS chairs and non-executive directors. Monitor (the former independent regulator of NHS foundation trusts) and the NHS Trust Development Authority (the former oversight body for non-foundation trusts) initially undertook the role of oversight for chairs and non-executive directors. More recently it has been a local trust role, supported by national guidance from NHS England. Any move towards reinstating a Code of Conduct for NHS Managers, along with an underpinning set of standards of leadership values and behaviours and a requirement for formal CPD would, I think need to apply equally to non-executive directors and chairs as to executive directors and other trust managers and leaders.

26. **The Fit and Proper Person's Test**. Another action taken to strengthen oversight of NHS management and leadership was the Fit and Proper Person's Test for NHS board members to try and assure fitness to practise. This was first proposed by the Francis Inquiry Report and implemented for people in board and other director-level roles in health and social care in 2014 [44]. A review of the operation of the Fit and Proper Person's Test undertaken for the DHSC by Tom Kark KC in 2018 reported that whilst the test was being applied appropriately in many trusts, this was not the case everywhere [45]. He noted that the test was applied more consistently for 'barn door' issues of unfitness to practise such as criminal convictions or bankruptcy, but less so for matters of more general competence, performance and fitness for a board level role which are critical to creating psychologically safe organisational culture.

27. Kark argued that there was too great reliance on a local voluntary approach and recommended that it be applied universally and based clearly on a set of core areas of competence which could be assessed as to whether an individual had sufficient experience and training for their role. He also proposed a central database of current and former NHS executive and non-executive directors, a mandatory reference form, extending the test to directors of commissioning organisations and arm's length bodies in the NHS, and setting up a Health Directors' Standards Council 'with the power to bar directors where serious misconduct is proved to have occurred.' He also proposed work to define elements of management and leadership practice that

would merit barring, including behaviour likely to discourage candour or supress the ability of people to speak up [45].

28. The response to Kark's review was made five years later in August 2023 with the publication of a framework for the Fit and Proper Person's Test [46] and then in February 2024 a leadership competency framework for board members [47] based on six domains as set out in box 2 below.

Driving high-quality and sustainable outcomes. Setting strategy and delivering long-term transformation. Promoting equality and inclusion, and reducing health and workforce inequalities. Providing robust governance and assurance. Creating a compassionate, just and positive culture. Building a trusted relationship with partners and communities. *Box 2: Domains for NHS leadership competence, NHS England, 2024*

29. The leadership competency framework guidance also set out a requirement that directors' fitness to be appointed and hold their role will be assessed under the categories of good character; possessing the qualifications needed, competence, skills required and experience; and financial soundness. The framework is intended to be used for board level recruitment, board member appraisals, to feed into personal development plans of executive and non-executive directors, and to inform national leadership programmes and 'support offers' (e.g. mentoring, coaching) for board directors and those aspiring to such roles. The strengthening of the Fit and Proper Person's Test seems to help close a gap that existed between the former test (more restricted to 'barn door' issues according to Kark) and the well-led framework developed in 2015 by NHS Improvement (a forerunner of NHS England) after the Francis Inquiry Report of 2013 and used by the Care Quality Commission in its reviewing and inspection work with NHS providers [48].

30. **The NHS Well-Led Framework for boards**. The NHS well-led framework comprises eight key lines of enquiry including the management of risk, organisational culture, leadership capacity and capability; and clarity of roles and responsibilities for governance and accountability [49]. Trusts are expected to undertake self-assessment every three years against the well-led framework, using external facilitation, and to use the resulting feedback as part of board and organisational

development [49]. The CQC rates the 'well-led' nature of a trust as part of its broader regulatory assessment about care quality and safety.

31. **Potential benefits for managers of regulation**. In discussions about the merits or otherwise of more formal standards for and oversight of NHS management and leadership practice, there has been rather more consideration of the downsides for managers and relatively little exploration of the potential benefits for board members or other senior managers facing ethical, leadership and other dilemmas. For example, having recourse to one's professional code of conduct might embolden a senior manager to feel more able to speak out about problems within their organisation, flagging what they consider to be irresolvable risks and why they may need external support. This might help counteract the pressures to 'give good news' and 'ensure no noise' explored in the context section of this statement. In similar vein, a code of conduct enshrined in the employment contract might support a middle manager or clinical leader in feeling confident to respond to 'whistleblowing' allegations from their service or department, knowing that they have a professional duty to do this, beyond any fear they may have of management reprisals. In addition, having a professional code of conduct could help a senior manager to be bold enough to prioritise a matter of safety or care quality even where it might compromise financial or other performance measures.

32. **Regulation of hybrid managers**. Those in hybrid management roles are subject to their professional regulation requirements, including CPD and revalidation, where they continue to hold a licence to practise. The General Medical Council has formal standards for medical leadership 'Leadership and management for all doctors', including planning, using and managing resources; raising and acting on concerns; and helping to develop and improve services [50]. These leadership standards form part of doctors' overall professional standards and apply to doctors at all levels of experience and training. The GMC issued updates to its standards in January 2024, including: the addition of 'formal leadership' being added to the areas in which a doctor must be competent (where applicable to their role); 'coaching' added as a suggested form of structured professional development; an expectation of helping to develop a fair, respectful, supportive and compassionate workplace culture; and similarly an expectation that doctors in a formal position of leadership have an important role in addressing damaging behaviours [51].

33. A similar set of leadership standards does not appear to have been developed by the Nursing and Midwifery Council, beyond those on 'leading and managing nursing care and working within teams' within the Standards of Proficiency for Registered Nurses [52]. These latter standards apply to nurses at and after the point of registration and it is not evident how they are to be applied for nurses in middle and senior management and leadership roles within NHS provider organisations.

34. The combination of the NHS Code of Conduct for Managers having dropped out of regular use and the somewhat mixed picture of how clinical professionals' regulatory codes and standards relate (or not) to their management and leadership practice, leaves hybrid (and other) leaders in an unclear and arguably exposed situation. In comparison with their clinical work, where underpinning standards of behaviour are clearly set out in a professional code of conduct, and linked to required CPD and revalidation, for management and leadership work, the underpinning standards and values remain more implicit than explicit.

35. **Moving towards regulation of NHS managers**. In a paper prepared for a seminar held by the Mid-Staffordshire NHS Foundation Trust Public Inquiry in 2011 [38], Professor Naomi Chambers and I drew on international experience of accreditation and regulation of healthcare managers, together with analysis of the approach taken in other public services in the UK, to argue that:

> 'It seems to us that moves to enact the recommendations of the Dalton Report (at least in respect of recruitment, vetting, corporate governance, and voluntary accreditation) will be necessary but not sufficient for the NHS. These will help to clarify roles and expectations, both for the NHS and the public, and to provide assurance of efforts to safeguard minimum standards. A lesson from various management failures of recent years is the risk of organisational and managerial isolation. What is also needed to go beyond the 'necessary' is a commitment to provide specific support to senior managers and boards (and to require organisations to take up such support, through professional standards) and for such support to include mentoring, coaching, peer networks, and confidential counselling.' [38] (p17)

36. This need for a form of regulation of NHS management and leadership along with a commitment to enable its professionalisation through greater investment in training and support is arguably ever more pressing. NHS managers work under immense pressure and scrutiny and suffer from poor public and media perceptions of their role

[2]. Furthermore, they are arguably rather isolated as a professional group, in need of the support that a code of conduct, formal CPD, and registration with a professional body might confer. Indeed, the Institute of Health and Social Care Management, a membership body which provides voluntary training and development support for some NHS managers [53] could perhaps be extended to become the formal professional body for all NHS managers.

37. Calls for government to 'take steps to enhance professional development and accountability of senior managers in the NHS' have come recently from the Professional Standards Authority, the body that oversees health and social care regulators in the UK [54]. It appears that NHS policy makers and senior managers also concur with the importance of assuring the highest standards of management and leadership practice, as reported by Messenger and Pollard [36]:

> 'We chose to focus on the current absence of accepted standards and structures for the managerial cohort within the NHS [...] it has long been a profession that compared unfavourably to the clinical careers in the way it is trained, structured and perceived, and we received strong feedback from managers at all levels that greater professional status and more consistent, accredited training and development are required.'

38. **Readiness for regulation of NHS managers**. What is less clear is how ready the NHS management community is to formally enshrine these standards and structures in HR and wider governance practice in a sustained and mandated manner. Steps towards more formal oversight – such as the Fit and Proper Person's Test, the Well-Led Framework regulated by the CQC, and the new NHS England Leadership Competency Framework – are welcome developments. Mandating and funding the various measures related to recruitment, appraisal, CPD and revalidation appears now to be a priority, along with clarifying which body would oversee and assure the universal adoption of such measures. In any move towards this more formal oversight of NHS managers and leaders, the spirit within which it is undertaken will be critical, ensuring an overall focus on the development and support of high calibre management and leadership practice [55]. In this way and following the advice of Professor Don Berwick in his review of NHS patient safety culture following the Francis Inquiry [6], greater oversight and regulation could be part of overall system learning and improvement and avoid an unnecessarily punitive approach which could risk reinforcing the harmful aspects of wider NHS management culture explored in paragraphs 98-119 (the critical yet complex role of culture).

Leadership qualities and behaviours for senior NHS managers

39. In this section, I examine the consequences of uncompassionate healthcare leadership before considering policy attempts that have been made to describe, codify and assure desirable NHS management and leadership behaviours. A suggested set of behaviours is made, drawing on three prior frameworks.

40. **The consequences of uncompassionate healthcare leadership**. An evidence review undertaken by the King's Fund in 2015 [56] and updated in 2022 to inform the Messenger and Pollard review of NHS leadership highlighted a series of consequences of uncompassionate leadership and organisational culture, and these included the factors set out in Box 3 below. These echo themes in the context section of this statement, such as the overarching NHS management culture that can be experienced as one of fear and blame, and the risk of stressed leaders passing their stress to those they manage. The potential harms for clinical staff are very striking, and the impact of broader pressures are of particular significance given the known workforce, waiting times, access and other challenges bearing down on the NHS over recent years [57].

> The complexity of health and care environments - with demands of regulation, governance protocols and political conflicts - can lead to a focus on chasing targets, and to cultures of fear and blame.
>
> The fear of making mistakes, time pressures, excessive and sometimes defensive bureaucracy, bullying, stress, depression, burnout, inadequate staff levels, job insecurity, complex clinical situations, difficult patients, rapid change.
>
> Stressed leaders themselves often pass their stress downwards. When leaders become pre-occupied with non-patient centred tasks this can diminish staff motivation and performance.
>
> The shift from person and people to diseases and bed capacity, can lead to the dehumanisation of patients and disengagement of leaders and staff.
>
> Clinicians who are unable to deliver compassionate practice, have been found to have: increased anxiety, and reduced autonomy.
>
> *Box 3: the consequences of uncompassionate leadership (adapted from King's Fund Library Service, 2015 and 2022)*

41. Research led by Professor Michael West analysing data from the NHS Staff Survey and the NHS Acute Inpatient Survey [58] underlined the relationship between 'leader

support' (the support that staff feel that they have from their leaders), staff influence over decision-making, work pressure and patient satisfaction. This study concluded:

> 'High quality, continually improving and compassionate care for patients, is dependent on supportive leadership, which lays the foundation for high quality, continually improving and compassionate support for staff.' [58, p7]

42. **The Healthcare Leadership Model**. Various attempts have been made to define standards for high-quality and compassionate NHS management and leadership, often as part of the establishment of a new national body to coordinate management and leadership development. For example, the establishment of the NHS Leadership Academy in 2012, which was part of the NHS England and DHSC response to the Francis Inquiry, was accompanied by the commissioning of a study by Storey and Holti [59] to develop a 'leadership model' that could be used in the NHS. This proposed three 'behaviours of leadership': provide and justify a clear sense of purpose and contribution; motivate teams and individuals to work effectively; and focus on improving system performance. The subsequent articulation of the NHS Healthcare Leadership Model built on the Open University study and was used for a decade to guide and underpin a wide range of development programmes and support for NHS leaders and managers, including the suite of programmes for all levels of leadership offered by the NHS Leadership Academy. The Healthcare Leadership Model comprised nine 'leadership dimensions': inspiring shared purpose; leading with care; evaluating information; connecting our service; sharing the vision; engaging the team; holding to account; developing capability; and influencing for results [60]. It should be noted that national bodies established to coordinate management and leadership development have often themselves been subject to reviews as with the Ed Smith review of centrally funded improvement and leadership development functions in 2015 [61].

43. **The Clinical Leadership Competency Framework**. Just prior to the establishment of the NHS Leadership Academy and the development of the Healthcare Leadership Model, the NHS Institute for Innovation and Improvement (in part the predecessor body of the NHS Leadership Academy) worked with the Academy of Medical Royal Colleges to devise a Clinical Leadership Competency Framework. This sought to describe clinicians' role in NHS leadership through all stages of training and practice and was used as the foundation for the standards now enshrined in the work of the Faculty of Medical Leadership and Management (see paragraph 44). The five domains of the Clinical Leadership Competency Framework were: demonstrating

personal qualities; working with others; managing services; improving services; and setting direction. A further clinical leadership framework was published by the NHS in 2021, this having been developed in response to recommendations made in 2018 to the Secretary of State for Health and Social Care to ensure more clinicians from all professional backgrounds take on strategic leadership roles [62].

44. **The Faculty of Medical Leadership and Management standards**. Building on research that called for greater professionalism in the development and support of clinical leadership [33], the Faculty of Medical Leadership and Management (FMLM) was established in 2011 by the medical royal colleges and has developed leadership and management standards for medical professionals [63]. The FMLM standards are intended to complement guidance from the General Medical Council on leadership and management for doctors, with a third edition of the FMLM standards issued in 2021. The standards are connected explicitly to the Nolan principles of conduct in public life [64] and the faculty offers five types of fellowship for doctors, from trainees to the most senior level.

45. **Developing people, improving care**. Developing People, Improving Care was published by the National Improvement and Leadership Development Board in 2016 [65] this being the first national framework for action on improvement and leadership development in all NHS-funded services. The framework was endorsed by all the main NHS and local government national bodies and the capabilities and skills asserted as critical for NHS staff were systems leadership; improvement; compassionate inclusive leadership; and talent management. However, by 2019 the National Improvement and Leadership Development Board no longer existed and the NHS Interim People Plan of 2019 [66] noted that:

> 'while Developing People – Improving Care has made some impact, it has not led to the widespread culture change it set out to deliver. In part, this is because the national bodies have not visibly demonstrated the importance of the framework and its vision, and in part because a framework alone is not enough to bring about this change.' [66]

46. **NHS Leadership Competency Framework**. As noted in paragraphs 28-29, a new competency framework for NHS board-level leaders was published by NHS England in February 2024. Its domains (Box 2) bear significant similarity to the Healthcare Leadership Model, the Clinical Leadership Competency Framework and the Nolan Principles in Public Life, yet there is arguably some overlap and gaps. The style,

format and content of these frameworks is markedly different from those in the Code of Conduct for NHS Managers and the GMC Leadership and Management Standards. The latter are set out in a more precise and personally focused manner, and when the GMC standards have been updated, a table is provided to indicate where changes have been made, why and what they mean for practice.

47. **Enduring principles for NHS leadership**. Rather than needing more work to define standards of behaviour for NHS managers and leaders, there are three sets of principles and behaviours that have stood the test of time and could be drawn together into an updated code of conduct. These are: the Nolan principles for standards in public life (selflessness, integrity, objectivity, accountability, openness, honesty and leadership); the Code of Conduct for NHS managers (see Box 1); and the principles set out by Professor Don Berwick (an international expert in patient safety) following his review of NHS patient safety culture in 2013 following the Mid-Staffordshire Inquiry 'A Promise to Learn, a Commitment to Act' [6] in Box 4:

Place the quality of patient care, especially patient safety, above all other aims.

Engage, empower, and hear patients and carers throughout the entire system and at all times.

Foster whole-heartedly the growth and development of all staff, including their ability and support to improve the processes in which they work.

Embrace transparency unequivocally and everywhere, in the service of accountability, trust, and the growth of knowledge.

Box 4: Core principles for the NHS as a learning organisation (Berwick, 2013)

48. Berwick also underlined the critical role of leaders in modelling a safe, supportive and trusting organisational culture [6] (page 15):

> 'Leadership requires presence and visibility. Leaders need first-hand knowledge of the reality of the system at the front line, and they need to learn directly from and remain connected with those for whom they are responsible. Culture change and continual improvement come from what leaders do, through their commitment, encouragement, compassion and modelling of appropriate behaviours.'

49. The central theme of Berwick's report [6] was the need for the NHS to have a 'pervasive culture that welcomes authentic patient partnership' (p18) and for it also to

be ‘firmly rooted in continual improvement’ rather than ever more emphasis on rules and regulation (page 38).

50. **Successive and overlapping standards and frameworks for NHS leadership**. As is evident from the examples set out above, the defining feature of policy attempts to describe and advocate for leadership and management behaviours and qualities in the NHS has been the periodic issuing of rather aspirational standards or frameworks, without clarity as to exactly how they are to be used, by whom, and when they will be reviewed and updated. Instead, each set of guidance and standards seems to be launched, promoted for a while, then allowed to wither on the vine whilst rarely being formally ‘retired’ or withdrawn, before a new framework or approach is published. This echoes what Professor Ted Marmor of Yale referred to as ‘policy fads and fashions’ or the ‘persistent pursuit of panaceas’ [67]. By contrast, the approach of the GMC and the FMLM, whereby standards are regularly reviewed and updated and used for the accreditation of training programmes and fellowships (and with the GMC for regulation) represent a more diligent and focused method of describing and assessing management and leadership behaviours.

51. Messenger and Pollard [36] similarly noted the importance of both formalising and harmonising their 2022 proposals for management standards with prior work on leadership standards and training:

> ‘a common symptom of change in hard-pressed organisations is that new initiatives are bolted on to, rather than merged into, existing frameworks. This only adds to complexity and inefficiency and inevitably lessens impact. There is certainly scope for rationalisation in the current approach, and we would encourage a root and branch re-alignment of leadership and management development.’

52. Messenger and Pollard set out practical suggestions for implementation and follow-up on their proposed approach to leadership standards, training and development, appraisal and assurance, clearly seeking to ensure that their recommendations would be what Professor Martin Powell has described ‘implementable’ [68] (see paragraphs 135-146, inquiry recommendations). It is however unclear what progress has been made in the two years since the Messenger and Pollard review, including in the context of ongoing reorganisation of NHS England and the introduction of Integrated Care Systems in 2022. There is arguably a need for a national board of

partner agencies to work together on NHS leadership and management to oversee and accredit standards, training and development on a sustained basis.

Training and development of NHS managers and leaders

53. In this section, I give an overview of the NHS' approach to training and developing its managers and leaders, highlighting the need for a more consistent approach underpinned by core standards.

54. **Central direction and local autonomy in training and development**. Arrangements for the training and development of NHS managers and leaders reflect the complex and diverse nature of this professional group, along with the combination of significant central policy direction and the relative autonomy of NHS foundation and other trusts noted in the context section of this statement. Indeed, the level of investment in learning and development by local NHS organisations is known to vary considerably [10, 65]. At a national level, various coordinating and commissioning bodies have existed over the decades, with a mission to assess training and development needs, design and commission programmes and other interventions, evaluate effectiveness of such programmes, and offer opportunities for managers and leaders to learn and network across professions and regions.

55. **The NHS Leadership Academy**. The NHS Leadership Academy was established in 2012 as a response to the Francis Inquiry and tasked with developing a comprehensive range of management and leadership development support to enable a more patient-focused and inclusive leadership approach and culture for the NHS [69]. Using the Healthcare Leadership Model, the NHS Leadership Academy designed and commissioned large development programmes for lay and clinical leaders at all levels of the NHS. The programmes attracted many thousands of participants over the past decade, including many clinicians. An independent review of the NHS Leadership Academy on its fifth anniversary in 2017 and described in the academy's annual report in 2022 [70] noted that:

> 'the Academy had impacted positively on leaders and leadership – and that, had it not existed, it would need to be invented. However, it highlighted that the Academy still did not have the universal reach needed to be truly transformational and there were still areas it was not touching.' [70]

56. Over time however, the Academy was moved between different central NHS bodies, and reductions in its funding meant that local organisations and participants had to find an increasing proportion of the resource for places on Academy programmes. The Academy is now in a further phase of transition and the question remains, as with predecessor bodies, about how its legacy will be handed on, what will come next and what attempts, if any, will be made to draw the many alumni of Academy programmes into a national talent management system.

57. **The provision of NHS management and leadership development**. NHS management and leadership training and development is provided by an array of national, regional and local providers within and beyond the NHS. Many NHS trusts have their own training and development department that offers or commissions management and leadership programmes, typically for first-line managers as they take up a supervisory role for the first time, but also often other programmes for more experienced and senior clinical and other leaders.

58. As noted in the section of this statement on the oversight and regulation of NHS management and leadership, there have been various reviews of NHS leadership and management and its training. In 2022, the King's Fund published a timeline that illustrates vividly the large number of reviews of NHS leadership that have been undertaken over the past 15 years [71]. Almost all of these have underlined the importance of having well-trained managers and leaders, the need for a coherent framework within which to design and deliver interventions and programmes, the risks of continuing with a rather patchwork approach, and a need for investment in a more structured and systematic approach that ensures that all receive core training and are supported in their career development. As Sir Stuart Rose put it [10] (p6):

> 'A few simple things would make a huge difference: some centralised effort on training; or helping middle managers keep their confidence and focus [...] At the start of their NHS career, everyone should have adequate training; in mid-career they should have adequate support and clear pathways to progression as managers; and top leaders should have the appropriate support and experience to enable them to make correct decisions.'

59. The assertion of a need for 'adequate training' at the start of an NHS management career reflects the lack of any standard requirement of what this should entail. Furthermore, as noted in the context section of this statement, approximately a third of NHS managers come from a clinical profession and may (or may not) have had

some management training previously. The Health Foundation underlined this point in a 2022 report Strengthening NHS Management and Leadership [72]:

> ‘A common complaint from the managers we interviewed is that they have had to work out for themselves how to be a manager. […] But what virtually all managers find is that the onus is firmly on them, unless they have a supportive supervisor, to find relevant training and then justify why it is necessary. Few it seems have access to a structured development programme in which they are expected to participate. As a result, there is significant variation in the training and skills of NHS managers.’

60. The Health Foundation study also highlighted that some local NHS organisations have agreed core values and management/leadership competencies, using these to structure job descriptions, appraisals, a transparent training and development pathway, management protocols and more, thus assuring a consistent and standardised management culture. This again reflects the federated nature of how local trusts interpret and respond to national policy exhortations (see paragraph 10).

61. **The NHS Graduate Management Training Scheme**. The NHS has a long-standing national graduate management training scheme dating back to 1956 as a relatively elite route into NHS management [73]. This programme was for many decades primarily for general managers, albeit there have been bespoke versions of the graduate scheme for in-service applicants and private sector entrants. Whilst the graduate scheme offers a well-resourced, diverse and comprehensive programme of skills training, work-based placements, action learning and coaching, along with an academic qualification, only a minority of NHS managers take this route into the service. Numbers recruited per year have varied, from around 50 in early years to 100 in 2015 and 250 in 2023-24 – this is however still a small percentage of the overall and managerial workforce, something that concerned Sir Stuart Rose in his 2015 review [10]. For a majority, they join as direct entrants into an administrative or junior management post, or laterally at middle or senior levels perhaps from a clinical profession or another part of the public, or private or third sectors. For most managers therefore, the extent to which they are trained in specific skills and competencies for their management and leadership role is largely a matter of happenstance and will depend on the approach to professional development taken by their NHS trust and line manager. As Messenger and Pollard noted [36]:

> ‘Managers who do not join via GMTS, often equally talented, do not benefit from the same profile or opportunities. Lateral entrants are often inadequately

inducted into leading and managing in context; and skills gained outside the sector, including those who have trained overseas, are not always fully valued. Clinicians who choose to take on leadership roles in addition to their clinical work told us they had little to no specific training to prepare them.'

62. **Talent management**. A perennial dilemma for the graduate management training scheme has been how to track, support and develop trainees following their time on the scheme. This reflects the broader issue in the NHS of having struggled to put in place a systematic process for talent management, something that was cited as a key concern by the Messenger and Pollard review [36], the Ed Smith Review of improvement and leadership development functions in 2015 [61] the Rose review [10], and the King's Fund Commission on NHS Leadership [74]. Each of these reviews expressed concern that in such a large and complex public service, there is no structured way of planning and supporting management and leadership careers, spotting and nurturing talent, or using core standards and competencies to underpin talent management as in the Civil Service, the military and others. Research into talent management in the NHS has pointed to the need for a more robust evidence base about what is intended from such an approach, and to ensure that 'the necessary infrastructure, culture and data for collaboratively delivering sustainable improvement is in place.' [75]

63. **Training and development for quality and safety**. Skills and behaviours for leadership of quality and safety in NHS organisations are needed equally at ward, department and service level for it is here that indicators of quality and safety can be particularly closely monitored, and concerns, errors or larger scale failings detected and reported upwards [76]. For managers at these middle levels – which research has shown to be notoriously difficult roles to hold [77] – training will be needed to ensure that managers can read different types of complex data, understand how to report and act on concerns, and support or challenge colleagues as appropriate to any discrepancy or incident. They will also require funding and time for training, a supportive leadership culture around them and critically, one that enables them to feel psychologically safe [78] in speaking up and responding to safety and care quality concerns.

64. Leaders at more and most senior levels of an NHS organisation likewise need to be appropriately trained and developed to understand in depth how clinical governance works in the NHS and in their organisation [76]. This will include being competent in

reading and understanding complex clinical and other data such as statistical process control charts, mortality data, rates of infections, serious untoward incident investigations, and NHS Staff Survey data analyses. Research by Professor Richard Lilford and colleagues has shown that such competence cannot be assumed and there is a clear need to plan training for board members (executive and non-executive) to ensure that they have the skills to read and interpret data outside of their professional background and comfort zone [79]. Research in Denmark has similarly flagged the need for board members to have access to data analytics and training that enable them to interrogate longitudinal trends in quality and safety [80]. As Mountford and Wakefield [81] noted when reflecting on these UK and Danish studies:

> 'A question for healthcare executives leading organisations to consider seriously is whether sufficient educational investments have been made to ensure its board members' analytic capabilities and sophistication are sufficient, particularly in the evolving era of 'big data'. A question for board members is whether the information they are presented with by executives leading their organisations provides sufficient information to make the best decisions.'

65. Recent research in the NHS has examined the broader issue of how far trust boards draw on research evidence to inform their decision-making, including whether senior leaders engage with such evidence in respect of matters of quality and safety, and if they are able to articulate needs and priorities in this area [82]. The study revealed a mixed picture of how evidence is used by boards along with a significant appetite to have greater access to research that can inform decision-making.

66. **Training and development for non-executive directors**. Training and development for chairs and non-executive directors of NHS organisations is, like other management support, neither mandated nor explicitly linked to a national core set of standards or behaviours. The former NHS Appointments Commission (abolished in 2012) had a role in overseeing training and development for NHS non-executive directors and chairs and Monitor, the former economic regulator for NHS foundation trusts also held this role (for foundation trusts) until Monitor (latterly NHS Improvement) merged with NHS England in 2019. The main training and development programmes now offered to NHS board members include those designed and commissioned by NHS Providers (the representative body for NHS trusts) and others from independent providers such as the King's Fund. This support

ranges from introductory programmes for new non-executives and chairs, training for committee chairs, NHS finance briefings, updates on specific policy priorities, bespoke programmes for individual trusts and more.

67. **Training and development of teams**. Leadership and management development is not only an activity to be undertaken by individuals as part of preparation for and continuing in a particular role. It is also critical for teams, where learning together is a core part of building shared values, exploring where the team has complementary or missing skills, having difficult discussions about ways of working and how they need to improve, all in the cause of nurturing a supportive and challenging culture [83].

68. This team as well as individual approach applies very much to NHS boards, just as to teams at other levels of an organisation [56]. As explored in the section of this statement on the role of NHS boards in quality and safety governance below, effective NHS boards need to have – and be able to use – a full repertoire of board roles and behaviours, honed through careful recruitment, ongoing training and development, and regular time spent working together and reflecting on core priorities and plans [84]. If a board is to be a well-functioning leadership team for an NHS organisation, it needs to model the leadership values, standards and behaviours that it espouses in its strategy and other documentation.

69. **Training and development for hybrid leaders**. Training for hybrid clinical managers and leaders is offered by providers including the NHS Leadership Academy, local NHS training departments, charitable foundations such as the King's Fund, university departments and medical schools, and private companies. Some programmes have been designed expressly for clinically trained managers and leaders. One example was the NHS Leadership Academy's Clinical Executive Fast-Track Scheme (CEFTS) which had a pilot cohort of 32 participants for a three-year programme that included residential workshops, action learning networks, career coaching, secondment opportunities and academic inputs. Evaluation of the pilot programme pointed to a range of benefits including participants valuing particularly the clinician-only cohort [85]. The programme has not however been recommissioned. Other institutions including the King's Fund have a long history of providing tailored management and leadership development education for clinical professionals. Clinically trained managers and leaders participate in many generic NHS development programmes and there are strong arguments for the value of such multidisciplinary learning, not

least the fact that most NHS managers and leaders work in highly multi-professional teams, services and organisations.

70. Sir Ron Kerr, in his review for the DHSC of the challenges faced by NHS executives, underlined the importance of management and leadership training being embedded into all clinical undergraduate and postgraduate education, including allied health professionals and social workers [4]. He argued for such education to include governance, finance and use of resources, systems and management, to better prepare students and trainees for future leadership roles.

71. **The need for national standards for management and leadership development**. Reflecting on the paper that Professor Naomi Chambers and I wrote in 2012 for the Francis Inquiry seminar on the training and development of NHS managers, there continues to be a need for a national framework of standards [86]. This would enable NHS management and leadership to be codified and valued as a professionalised activity. Such standards could be used to develop core requirements for training and development, embedded in appraisal and even some form of revalidation. Until this happens, there will continue to be variation in the extent to which NHS managers and leaders have access to necessary training and support, with some missing out altogether. Addressing this will require significant investment but given that the NHS is relatively under-managed in the international context [87] and the need for high-quality and well-trained executive and non-executive leadership has been emphasised in multiple inquiry reports [e.g. 5, 37, 88], this would seem to be a necessary and implementable priority.

The role of NHS boards in quality and safety governance

72. In this section I explore the board's role in governing and accounting for the quality and safety of patient care. Topics include the critical importance of the chair-chief executive relationship; a well-functioning system of clinical governance including a board quality committee; a council of governors that operates effective scrutiny of the board; and having a board that can deploy the full repertoire of desirable roles and behaviours.

73. **The trust board's accountability for quality and safety**. Sir Robert Francis KC underlined the primacy of the board responsibility for quality and safety of care in his statement when publishing his public inquiry report [89, p9]:

> 'the story [the inquiry report] tells is first and foremost of appalling suffering of many patients. This was primarily caused by a serious failure on the part of a provider Trust Board. It did not listen sufficiently to its patients and staff or ensure the correction of deficiencies brought to the Trust's attention. Above all, it failed to tackle an insidious negative culture involving a tolerance of poor standards and a disengagement from managerial and leadership responsibilities.'

74. Professor Naomi Chambers and I [86] drew on research evidence to describe the core functions of NHS boards as to: determine strategy (direction); assess performance (control); and shape organisational culture (values, roles, tone). These functions chime with those in the NHS England Well-Led Framework (see paragraph 30). Furthermore, the Code of Governance for NHS provider trusts [90] in articulating NHS board leadership notes the importance of:

> 'ensuring decision-making complies with the triple aim duty of better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS resources. […] All directors must act with integrity, lead by example and promote the desired culture.'

75. **The chair – chief executive relationship**. In NHS England guidance about the role of the chair of an NHS provider organisation [91] the critical importance of their relationship with the chief executive for the overall performance of the board and organisation is underlined:

> 'To carry out their role effectively, the chair must cultivate a strong, collaborative relationship with the chief executive […] It is important the chair and the chief executive are clear about their individual and shared roles, and their respective responsibilities towards the unitary board. Together, the chair and the chief executive set the tone for the whole organisation.'

76. Later in this guidance, it is noted that the chair is responsible for 'ensuring that constructive relationships based on candour, trust and mutual respect exist between executive and non-executive directors'. Research evidence further underlines the importance of the chair-chief executive within public and private sector organisations, and the need for this to be open, trusting and respectful, based on an appropriate mix of support and challenge [92, 93, 94].

77. Cornforth and MacMillan (2016) in a study of chair-chief executive relationships in the non-profit sector [95] similarly highlight its critical nature, noting that it will need to be regularly renegotiated over time as circumstances change, and to ensure that the risk of one party dominating the other is mitigated. They refer to the work of Pettigrew and McNulty [96, 97] in drawing attention to the need for a chair and chief executive to both carefully exercise 'will' and 'skill' in how they use their influence within the board and organisation. The chair-chief executive relationship must however comprise a judicious mix of support and challenge if to be effective, avoiding the risk of being overly close or cosy. In this way, it must reflect the need for an appropriate balance of non-executive and executive challenge [98]. This was underlined by Exworthy and Robinson in a study of NHS chairs and chief executives [92] and summarised thus:

> 'Creating a constructive tension, therefore, needs to facilitate an effective partnership whilst at the same time avoiding complacency. The challenge for all Chairs and CEs is to establish and maintain this tension throughout their relationship.' (p90)

78. Whilst the corporate board model of governance is based on the concept of a separation of non-executive and executive responsibilities, evidence from research and practice highlights the importance of there being trusting, respectful and effective relationships across this boundary. The chair-chief executive relationship is at the heart of this 'bridging' of the two sets of directors and the crafting of a board culture that can set an appropriate tone and assure effective strategic leadership and accountability for the organisation [18, 76].

79. **The connection between effective board practices and care quality and safety**. There is a body of research evidence that confirms the connection between effective board practices, high-quality healthcare management and enabling improved care quality and patient safety. For example, a research study of hospital board competencies across the NHS found a link between particular board competencies and staff feeling confident about raising concerns; and that of staff feeling confident that their organisation would address such concerns [99]. A review of international research evidence by Millar et al [100] explored the relationship between the performance of hospital boards and measures of patient safety and care quality. The study applied the following overarching criteria in making its assessment of the relationship between boards and patient safety and care quality:

- leading for safer care;
- measuring safe care;
- implementing internal board oversight; and
- relying on external regulation and accountability.

80. This international review found clear differences between high- and low-performing hospitals and noted the particular importance of the following governance practices associated with higher performance in respect of care quality and safety (Box 5):

Routine feedback and monitoring
Spending time on quality issues
Using quality performance reports
Regularly reviewing dashboard indicators to monitor quality

Strategic practices
Involving medical staff in the development of quality strategy
Having a quality subcommittee
Developing new clinical programmes and services to meet quality-related criteria

Wider systems of governance
Exploring different ways of producing public reports to enhance transparency and accountability to the community
Having equal involvement of board and medical staff in setting the agenda

Box 5: Board governance practices associated with higher performance for quality and safety (Millar et al, 2013)

81. NHS hospital boards vary in terms of their behaviours and cultures reflecting the local discretion referred to in paragraph 10, despite significant national policy direction and performance management. In-depth qualitative ethnographic observational research of hospital board meetings in the NHS has shown this local variation can have profound implications for patient safety [101]. In similar vein, Tsai et al [102] studied hospitals in the US and UK exploring the relationship between leadership and care quality. They established that more effective board and hospital management practices were strongly associated with higher quality care. This study, like Millar et al, underlined the importance of a hospital board paying greater attention to care quality and safety and using clinical quality metrics in an effective manner [102].

82. Empirical research led by Professor Naomi Chambers and of which I was a co-investigator [103] into NHS healthcare trust boards' response to the findings of the Francis Report concluded that there was a need for effective boards to be 'restless

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and diligent', with an urgency about trying always to improve patient safety and care quality, whilst diligently attending to matters such as following up on prior concerns and actions. This research suggested factors (see Box 6) for improving board leadership that is focused on care quality and safety (over and above financial matters):

> Having a strong and effective human resources function
>
> In-house programmes to improve governance of quality and safety
>
> A programme of work to improve relationships with other local NHS bodies
>
> Being able to sustain (in the eyes of staff) reliable, consistent and clear messaging
>
> A body of governors and patient representatives who are engaged closely in quality and safety work
>
> Using complaints and incidents as part of a wider programme of trust learning and review.
>
> *Box 6: Factors required for NHS board leadership focused primarily on care quality and safety (Chambers et al, 2018)*

83. **NHS boards and clinical governance**. These studies underline the importance of a healthcare organisation having a well-functioning system of clinical governance. Legislation in 1999 enshrined in law a 'duty of quality' for NHS providers, with the board of a trust being responsible for this alongside their fiduciary responsibility to balance the books [26]. NHS trusts need to have an effective clinical governance system whereby data and information about the quality and safety of patient care are available to managers and leaders (including clinical service leads) at all levels of the organisation. This is to enable local teams and departments to monitor the quality of care within their area, explore trends and patterns of improvement or deterioration, take action to address any concerns, lead work to improve services, and respond to untoward and serious incidents that are reported. The importance of such clinical governance 'from ward to board' was underlined by Dr Bill Kirkup [104] (p70) in his report into the failings of maternity care at Morecambe Bay:

    > 'clinical governance depends critically on the quality of information being communicated to the Board about clinical services and their outcomes, to enable informed assessments of the safety and effectiveness of services and, if necessary, action to improve them.'

84. **A chief quality officer role**. Professor Sir Nick Black of the London School of Hygiene and Tropical Medicine, an international expert in health services research and clinical audit has argued for a new role of chief quality officer to be in place on all NHS trust boards in addition to the roles of medical director and chief nurse. In 2014 he described the chief quality officer role as follows [105]:

> 'We need chief quality officers with vision to lead, inspire staff and facilitate rigorous assessment and improvement of quality throughout their trust. They will need to possess expertise in: the technical and scientific aspects of how to assess all the domains of quality (effectiveness, safety, experience); understanding of behavioural and organisational barriers to achieving change; and awareness of the constantly shifting arena of national policy developments, all of which have consequences locally for healthcare quality'.

85. **The critical role of the board quality committee**. It is considered standard good practice for an NHS trust to have board sub-committees through which it can do its more detailed work, scrutinising the performance of the organisation, supporting and challenging executive directors and other senior staff about key areas of activity, and gathering insights from which to inform the wider work and governance of the trust board [106]. A caveat to this is often cited as it being important that such committees are effective, well-run and avoid being a 'talking shop.' There is no requirement in primary legislation for a trust board to have subcommittees, however secondary legislation requires NHS trusts to have an appointments committee, and NHS foundation trusts to have an audit committee and a remuneration and/or nominations committee [106]. Most trusts have a finance committee as well as an audit committee and a remuneration/appointments committee, and most have a quality committee. Given the statutory duty on NHS bodies to assure quality as well as finance, having a board quality committee would seem to be of vital importance alongside a finance committee, and this has been noted in international research as an effective board governance practice [107] Indeed, an NHS trust is required to file annual quality accounts [25] alongside its financial accounts, which indicates the importance of having systematic, data-informed, and non-executive director-led scrutiny of quality and safety. A quality committee will usually be chaired by a non-executive director and have as members other non-executives, the chief medical officer and the chief nurse. NHS Providers [106] in their guidance about effective board assurance through committees, set out the importance of these factors (Box 7):

Ensuring that a board committee has clear and regularly updated terms of reference.

Works in a purposeful manner.

Has the right (and not too many) people at its meetings.

A clear work plan and focused agendas.

Appropriate papers with clear and comprehensive data supported by explanatory narratives.

Box 7: Key requirements of effective board assurance through board committees (NHS Providers, 2023)

86. NHS Providers point out that it will often be necessary to have other meetings feeding into board committees (for example, in the case of a quality committee, health and safety, clinical quality, non-clinical quality, and patient experience). It would be considered good practice for the quality committee to have assigned to it from the trust board certain risks that form part of the trust's board assurance framework, thus ensuring that the work of the quality committee is integrated with core risks and priorities of the trust. To assure the effective working of the quality committee, the audit committee would typically review the working of all board committees on a regular basis, perhaps requiring each committee chair (including the quality committee chair) to attend audit committee annually to report on how the committee is working, share concerns and seek advice on any improvements or changes needed. In this context, the presence at audit committee of internal and external trust auditors could prove helpful in offering insights from quality committee practice elsewhere in the NHS.

87. **Capacity and capability for board oversight of quality and safety**. Research into effective healthcare board working and governance has pointed to the value of having sufficient non-executive clinical expertise both on a board and its quality committee [18, 76] in enabling appropriate challenge to executives and interrogation of data and issues, based on understanding of potentially complex clinical issues or trends in data. As explored in the section of this statement on the training and development of NHS managers and leaders (paragraphs 63-66), it is important that NHS executive and non-executive board members, and particularly those on the quality committee, have tailored and regularly updated training in how to read and interpret complex quality and safety data. They will need to be skilled not only in understanding the data and charts provided to them but also to know what other

information they need, where it might be sourced, and in what format it is required. For example, if concerned about a particular service in a trust, the quality committee will need to know how to access longitudinal data about untoward incidents, mortality, infections, staff absence, staff experience, staff retention, and patient complaints. It will also be important to understand how a trust benchmarks its quality and safety data against local and national NHS peers, and how it has responded to and is following up on the findings of external reviews and inspections.

88. McNulty et al. [108] suggested that the effective non-executive director was 'independent but involved', 'challenging but supportive' and 'engaged but non-executive'. This need for what Chambers et al (2017) [109] termed 'positive creative tension' between dyads of behaviour is at the heart of effective board governance practice. Chambers et al [109] emphasised the need for non-executive board members to 'deploy discretionary effort to engage with the business of the organisation', namely the need to ensure that they have sufficient connection with and insights about the operations of the organisation to enable robust challenge of executive directors. This might entail taking part in purposeful visits to different departments, being a safety champion for certain service areas within the trust and finding ways to maintain clear visibility and appropriate connection with the core work of the organisation.

89. **The council of governors and oversight of quality and safety**. The council of governors of an NHS foundation trust (see paragraph 14) has a statutory role in monitoring the quality and safety of care and holding the non-executive directors of the trust to account. This includes receiving and approving the annual quality accounts of the trust. Governors have been described as representing a 'corporate conscience' [110] for an NHS foundation trust board or 'meta-regulators' [111, 112] playing a role in regulating internal self-regulation and providing a check and balance. Millar et al's research in the NHS concluded that although there was real potential in the role of governors as an additional form of governance of quality and safety, too often the role is largely symbolic and 'legitimising the interests of Executive board members' [112, p22].

90. **Board curiosity about and challenge of quality and safety matters**. Having a committee furnished with data on quality and safety is important but not sufficient. It is vital that committee members are constantly curious about issues discussed, data

presented, and more. In this way, they need to act in the 'restless and diligent' manner outlined in Professor Naomi Chambers' team's research [84]. Another body of evidence about NHS quality and safety and its governance comes from the work of Professor Mary Dixon-Woods and her team at The Health Improvement Studies (THIS) Institute at the University of Cambridge. Drawing on a large programme of research examining culture and behaviour in the NHS, Dixon-Woods and colleagues [113] asserted the importance of leaders being 'problem-sensing not comfort-seeking', pointing out [p113]:

> 'This means actively seeking uncomfortable and challenging information from patients and staff, rather than relying solely on formal data collection against narrow performance indicators that may not give a fully rounded picture of quality of care.'

91. The Cambridge team also highlighted the need for clear goals and priorities for care quality and safety 'from ward to Whitehall' and avoiding 'policy thickets' of too many and overlapping priorities. This echoes Ted Marmor's assertions about policy fads and fashions [67] (see paragraph 50) and the multiple reviews, frameworks, standards and policy pronouncements exhorted of NHS boards and organisations, yet without clarity of priorities.

92. Professor Mary Dixon-Woods has emphasised the importance of NHS organisations making sure that they have access to multiple sources of information to help them monitor and understand clinical and other service data, thus being able to detect and act on problems and undertake necessary remedial and improvement work [113]. This builds on prior work by Professor Maria Goddard and colleagues which examined the need for trust boards to be able to see, understand and integrate hard information such as performance measures with soft intelligence drawn from their informal networks (including staff speaking up) and other forms of 'voice' by staff and patients [114].

93. This need for boards to ensure that they have a full repertoire of roles and behaviours, to deploy in order to fulfil their various roles and obligations, was summarised by research led by Professor Naomi Chambers (and of which I was a co-investigator) [103], and these board purposes, roles, mechanisms and intended outcomes are summarised in table 1 below.

Theory about the purpose of the board	Contextual assumptions	Roles and modes of behaviour	Mechanism	Intended outcome
Agency (holding management to account)	Low trust and high challenge and low appetite for risk	Board as sensor challenging, supportive	Holding to account and control through intense internal and external performance monitoring	Minimisation of risk and good patient safety record
Stewardship (supporting management)	High trust and less challenge and greater appetite for risk	Board as coach collaborative, inquiring	Broad support in a collective leadership endeavour	Service improvement and excellence in performance
Resource dependency (enhancing the reputation of the organisation)	Importance of social capital of the organisation	Board as diplomat ambassadorial, curious	Boundary spanning and close dialogue with healthcare partners	Improved reputation and relationships
Stakeholder (representing interests of all stakeholders)	Importance of representation and collective effort; risk is shared by many	Board as conscience listening, questioning	Collaboration	Sustainable organisation, high levels of staff engagement
Board power (reconciling competing interests)	Human desire for control	Board as shock absorber Courageous, probing	Use of power differentials	Equilibrium

Table 1: Revised theoretical framework for effective healthcare board roles. Chambers et al, 2018, p178

94. **Issues specific to the scrutiny of maternity and neonatal care quality and safety**. For the boards of NHS trusts providing maternity and neonatal services, there are additional requirements for data collection and review of maternity and neonatal safety. Some of this additional scrutiny has been put in place as a response to the two reports of an inquiry carried out by Donna Ockenden into the maternity and neonatal services at Shrewsbury and Telford Hospital NHS Trust [115, 116]. For example, her interim report recommended that Local Maternity Systems have oversight of local investigations into serious incidents, and an independent senior advocate role be established to report into trust and Local Maternity System Boards.

95. Other aspects of this maternity and neonatal scrutiny (for example, the requirement to appoint board maternity safety champions) track back to Better Births: improving outcomes of maternity services in England – a five year forward view for maternity care, a national maternity review that was chaired by Baroness Julia Cumberlege [117]. This review formed part of the NHS Five Year Forward View [118] and was also part of the NHS England response to the Morecambe Bay inquiry. Board maternity safety champions have specific responsibilities and need training and development support for carrying out their role, along with validation from the trust chair and board to have adequate time to present issues and concerns to the board for discussion, action and approval.

96. There will also be a need for robust processes for champions to connect their insights from the frontline into overall trust clinical governance, quality committee and board assurance processes. In a trust that provides maternity and neonatal services, there will be an additional level of responsibility on the quality committee and its members to be assured that they have the skills and expertise to oversee these services, understand and interrogate clinical and organisational data, and be fully aware of the complex reporting requirements specific to maternity services. These include data provided to and reports made by bodies such as the MBRRACE-UK on perinatal mortality, the Local Maternity System on a range of maternity and neonatal outcome indicators, the Maternity and Newborn Safety Investigations (MNSI) programme, the Maternity Services Data Set, Clinical Quality Improvement Metrics, and the CQC Maternity Survey.

97. **Board assurance and the role of the board secretary**. The board assurance framework is the overarching governance tool for assuring quality and safety of care and services within an NHS trust, typically curated and updated by the board secretary, based on discussion at board meetings and taking advice from board committees. The role of the board secretary is one that is important and not often discussed. They are in effect the guardian of board assurance processes, including how committees feed into the board and vice versa, overseers of terms of reference for governance meetings, and a key conduit between the trust board and the council of governors. In a paper for a Francis Inquiry seminar in 2011 [86], Professor Chambers and I described the role of the board secretary as follows [86, p11]:

'The influence of the board secretary, described variously as *silent servant* or *eminence grise* in ensuring the professional and effective running of the board should not be under estimated. This specialist role is at the centre of the arrangements for corporate governance of the healthcare organisation. The company secretary is a key maintainer and developer of effective systems of good governance within their organisation.'

The critical yet complex nature of culture

98. In this section I examine the relationship between organisational culture and care quality and safety, with a focus of the problematic nature of NHS management culture and its interplay with boards.

99. **Culture as a root cause of care failings**. Culture has become increasingly central to discussions about improving healthcare quality and safety, having been given impetus by major reports highlighting the scale of harm to patients in the US and UK and by NHS inquiries that have 'alighted on organisational culture as the primary culprit at the root of scandals' [119], Examples include the Bristol Inquiry where 'club culture' was used to describe excessive power and influence associated with a core group of senior clinicians and hospital managers [120] and the Mid-Staffordshire Inquiry where Sir Robert Francis KC concluded that the culture was more focused on 'the system's business rather than the patients' [5, p4].

100. Researchers have endeavoured to explore the links between culture, healthcare quality and organisational performance, something that is not an easy task [121]. Professor Jeffrey Braithwaite and colleagues in Australia undertook a systematic review in 2017 of international evidence on healthcare, culture and performance which concluded that there was a 'consistently positive association between culture and outcomes across multiple studies, settings, and countries' [122, p4].

101. **Defining and understanding culture**. Defining culture is not straightforward, and multiple attempts have been made [119]. Professor Russell Mannion [119], drawing on the seminal work of Edgar Schein [123] asserts that:

    'Given the plethora and diversity of perspectives, a universally accepted definition of culture is unlikely ever to be achieved. But at the heart of many definitions is the view that culture comprises that which is shared and taken

for granted between members of an organisation. […] Culture can be viewed as the sea within which we all swim in our various organisational environments.'

102. Dr Dawn Goodwin, in a paper exploring 'public inquiries and the problem of culture' [124] set out the following definition of culture: 'the prevailing beliefs, values, assumptions and attitudes of a community, and their translation into patterns of behaviour, organisational routines and rituals.' [124]

103. Goodwin also noted that culture is both a product of and context for social action. In other words, culture is shaped by a team, professions, organisation and its surrounding system, but is also the context within which health care is practised, and if that culture is unsupportive, fearful or closed, then services and care may be compromised. Davies and Mannion [125] drew on a wide body of research to assert that culture in large complex organisations is rarely uniform. They suggested that it makes sense to consider a healthcare organisation as a complex and dynamic 'cultural mosaic' with: 'multiple (often competing) subcultures, stratified by hierarchy, hospital, service, ward, team, and, most obviously, occupational group.'

104. This complex mix of cultures and subcultures within an organisation makes it difficult for recommendations by inquiries or policy makers to effect desired change [126]. An example of the scale of attention and effort that might be needed to bring about cultural change in a healthcare organisation is reported in research led by Professor Mary Dixon-Woods into a major healthcare organisational failure in the United States, one that was defined by staff feeling unable to speak up about transgressive behaviours. To try and remedy the situation, there was a need for extensive diagnostic work (including playing back to the senior leaders of the organisation the very tough findings from interviews and observations) followed by a structured programme of training and development, plus other interventions including the removal of some individuals from positions of power within the organisation [127].

105. Culture is never static. It is continuously recreated by people within an organisation, for the policy context may change, key staff leave, and new technologies be introduced [124]. A diverse range of conceptual frameworks for understanding the stages of culture change are summarised by Professor Russell Mannion in a book for Cambridge University [119]. In this, Mannion notes that despite some significant differences between these frameworks, they share some common elements

including: crises as a trigger for significant organisational change; leadership in detecting the need for change and articulating the problem that needs to be addressed and how; re-learning and re-education as a way of embedding the need for new cultures; and identifying ways to consolidate the new order and counter natural resistance to change.

106. In similar vein, Dr Dawn Goodwin argues that culture can change following a major shock such as a public inquiry and suggests that after the Bristol Inquiry, there has been less paternalism evident in medical practice, this being associated with greater transparency of clinical performance data and the embedding of clinical governance. Ruth Thorlby and I [128] have similarly asserted in a conference paper that the introduction of the 'duty of candour' into the NHS following the Francis Inquiry has encouraged a greater degree of openness about incidents or near-misses involving patient care albeit research indicates that more still needs to be done to fully embed this approach [129].

107. **Culture and teams**. The importance of culture within healthcare organisations has also been explored in terms of how various levels of the organisation can significantly affect culture and its associated behaviours. For example, Dr Joanne Lyubovnikova, Professor Michael West and colleagues have emphasised the crucial nature of having properly effective teams within healthcare organisations, as opposed to what they term 'pseudo teams' [130].

108. West argues that NHS staff need to feel 'psychologically safe' [78] within their team and have training to enable them to work effectively in teams, in a manner that reflects collective, consistent and compassionate leadership [131]. Professor Naomi Fulop and Dr Angus Ramsay in a major review of evidence on healthcare governance similarly underline the need for effective teams as a core part of governing for safe and high-quality care, and assert the vital function of leading such teams in a way that assures psychological safety [76]:

> 'Leadership is frequently identified as central to fostering team cultures and behaviours that support high-quality, safe care. This includes the creation of psychological safety, whereby team members feel that they can raise questions or share concerns or fears with their colleagues.' [76]

109. Culture also impacts those leading a healthcare organisation, both the way in which a board works or not as a team (echoing Professor Michael West), and how it is

influenced by the wider local and national health system. NHS inquiry reports have underlined the crucial impact on local NHS boards, leaders and organisations of this surrounding culture, where performance management and policy direction may become overbearing (paragraphs 8-9). Messenger and Pollard in their 2022 review of NHS leadership [36] noted:

> 'These symptoms [of poor behavioural cultures] are […] the result of a combination of factors over many years; some structural, some cultural, some emanating from behaviours at the top, including politicians, some born of complex inter-professional and status issues in the workplace.' [36]

110. **Levels of organisational culture**. Despite debates over the precise meaning of organisational culture, most commentators agree that it is layered in nature [126]. The work of Professor Edgar Schein [123] has been particularly influential here, with his framework of levels of culture: (i) surface-level attributes including the physical and social environment, and workplace rites and rituals; (2) beliefs and values including social principles and ethical codes, these being largely unwritten yet used to justify behaviours and choose between courses of action; and (3) often unconscious and unexamined perceptions and expectations shared by colleagues about how things 'work' in the organisation and how people should behave.

111. Mannion and colleagues [132] when reporting on a study of healthcare scandals and professional wrongdoing, proposed a four-level framework for thinking about the ways in which levels of organisational culture impact on the behaviour of staff, teams, and leaders. First, they pointed to 'bad apples', people who repeatedly display unprofessional behaviours. Second, they described 'bad barrels' the local organisational culture which is inimical to good practice (echoing West's assertion of the importance of properly effective and safe teams and services). Third, they pointed to 'bad cellars' which they suggest are the regulatory environment, policy directives and values where they may conflict with those of local professionals and teams (echoing Messenger and Pollard). Fourth they suggested that 'bad orchards' play a role too, these being the professional and educational context to healthcare where for example doctors or midwives may be more socialised by their initial professional training than by the organisation in which they work. Importantly, Mannion and colleagues underlined the vital role and responsibility of individuals within such layered organisations, including those who do wrong, and those who draw attention to and seek to address wrongdoing [132].

112. The use of these 'apple metaphors' is helpful in highlighting the different ways in which a healthy, trusting and open organisational culture is developed, nurtured and led and the risks of not doing so. The team and service can only do so much however – they require clarity of values, standards, incentives and consistency of behaviour as espoused and enacted by their board, and by the wider regulatory and performance management system of the NHS. Dr Dawn Goodwin, reflecting on the Francis Inquiry and the evidence given about poor local organisational culture [124] noted that:

> 'Consultant staff became disengaged from managerial decision making because of the perception that the raising of concerns was not welcomed by senior management, and that to do so would risk job security. Moreover, when concerns were raised, the response was generally defensive of the Trust leadership's position' [124, p4].

113. The role of the surrounding system (the barrel or orchard in Mannion's terms) in creating an oppressive and sometimes bullying culture in the wider NHS context has been cited in inquiry reports (e.g. Kirkup in Morecambe Bay, Francis in Stafford) and in reviews of NHS leadership, including by Messenger and Pollard [36] and by Kerr [4]. Kerr stated 'In reality, a culture of blame and negativity continues to pervade the NHS' [4, p6]. He said he had 'found strong evidence of a culture of "negative behaviours" which often stemmed from the different relative priorities and pressures between regulators and organisations' (op cit, p13). Kerr, who is currently the Chair of NHS Providers, connected this problematic culture and associated behaviours with a reported reticence on the part of some NHS leaders to speak out about problems for 'those who do so are seen as at fault or inadequate.' (p16) Recent research led into unprofessional behaviours led by a team from the University of Birmingham has explored the link between these behaviours and patient safety [133].

114. **The problematic nature of NHS management culture**. As noted earlier in this section, there is no single NHS management culture but rather a 'mosaic' of local cultures. The wider NHS system architecture and behaviours and relationships between the players can however create a negative and toxic environment in which leaders have to operate (see context section of this statement). The problematic nature of this aspect of NHS management culture is a theme that recurs across decades of inquiries. Research evidence on this complex topic is not easy to find for the culture itself can inhibit senior NHS managers from describing their experiences. Sir Robert Francis KC commented on this as follows:

'the evidence has shown that an unhealthy and dangerous culture pervaded not only the trust […] but the system of oversight and regulation as a whole and every level'. [134, p1360]

115. Professor Chris Ham noted that Messenger and Pollard, in their review of NHS leadership made the connection between the downsides of an overly centralised management approach by the policy and political centre and resultant unacceptable behaviours which contribute to an unhealthy organisational culture [135]. Messenger and Pollard [36] reported that 'we have encountered too many reports to ignore of poor behavioural cultures and incidences of discrimination, bullying, blame cultures and responsibility avoidance.' They were clear that 'they can be tackled but only through determined cultural change from the top of the system to the front-line.'

116. A centralised public service like the NHS too often falls back on what Bevan and Hood [136] called 'targets and terror', setting multiple national objectives for local health care organisations, enforcing them through a range of sanctions (and sometimes incentives), and using tried and tested management approaches to seek compliance. Research into the growth of performance measurement in the NHS has revealed a range of unintended and dysfunctional consequences for patients and staff with sometimes deleterious consequences for quality and safety [15].The perverse nature of such a regime continues to be debated, as in the 2023 review by Patricia Hewitt of recently established Integrated Care Boards, who argued for these bodies to be given fewer national targets and more local flexibility in respect of priorities and how they are monitored [137]. Roger Kline, an academic who has written extensively about bullying, poor behaviour and discrimination in the NHS has similarly noted [138]:

> 'Command and control are deeply embedded in senior NHS leadership behaviours. Status and funding are used to either support or, in effect, beat up local leaders, confusing bullying with accountability. The behaviours of national bodies largely shape what local leaderships do or don't do'.

117. The NHS policy centre (DHSC and NHS England) appears too often unable to be self-critical or demonstrate sustained learning in respect of its behaviour towards those NHS leaders looking to it for guidance, support and direction [2]. Unless change happens at this level, it is hard to see how the culture of many local NHS bodies can also change for the better, as it will likely be the more experienced and longest-serving executives who feel resilient and confident enough to challenge or

deflect the worst excesses of toxic and stifling management behaviour. Messenger and Pollard underlined this in their review:

> 'Although by no means everywhere, acceptance of discrimination, bullying, blame cultures and responsibility avoidance has almost become normalised in certain parts of the system, as evidenced by staff surveys and several publicised examples of poor practice.' [36]

118. The risk posed by this sometimes unforgiving and oppressive culture experienced by senior managers in NHS trusts is that their impulse will primarily be to look up the line and worry more about reputation management and perhaps less about listening sufficiently carefully to and heeding concerns raised by patients and staff [5, 36]. Furthermore, NHS staff (and managers) may experience a disconnect between supportive national and local rhetoric about values, behaviours and culture and the different or even toxic reality in some NHS workplaces and systems. As noted in the section of this statement on oversight and regulation of NHS management and leadership, regulation itself could fall into this same trap, as a regulatory framework without a commitment to cultural change and investment in training, development and support could result in more of the same.

119. **Ensuring a healthy board culture**. The board of an NHS trust is, as noted in the NHS Trust Code of Governance, the Well-Led Framework, and longer ago the Healthy NHS Board Principles for Good Governance [139] responsible for setting and upholding a healthy organisational culture. Furthermore, the board must model this culture in its own behaviours, employing the full repertoire of board behaviours [84] needed to achieve its objectives in a manner that enables safe and high-quality care along with appropriate financial balance. A healthy board culture will be perceived by managers and staff to be properly open to hearing about concerns and problems, as well as ready to celebrate progress where appropriate. Critically, staff and leaders at all levels, from ward to board, will need to feel able and safe to speak out about concerns, confident that they will be heard and heeded, and not suffer unfair or undue consequences as a result.

Openness, speaking up, hearing and responding

120. The ability or otherwise of staff to be able to raise concerns within their organisation – something that used be known as 'whistleblowing' but is now more commonly referred to as 'speaking up' – is considered an important indicator of the health or

otherwise of an organisation's culture [140]. In this section, I use research on speaking up as the basis for considering how this aspect of healthcare organisational culture might be improved.

121. **Whistleblowing or truth-telling**. The role and treatment of whistle-blowers or, as the original NHS whistleblower Graham Pink termed it [141], 'truth-tellers' has been a key feature of many NHS inquiries. Dr Steve Bolsin in Bristol raised concerns about paediatric surgery and ended up having to emigrate to Australia to re-establish his career. Dr Chris Turner and nurse Helene Donnelly were key whistle-blowers at Stafford, and both moved on to roles in other organisations. There has been something of a pattern of poor and even bullying or undermining treatment of those who speak up to air concerns [142].

122. **The NHS and speaking up**. Evidence from NHS staff suggests that speaking up remains difficult or impossible for many, and that the culture in some organisations remains antithetical to this. The NHS ombudsman Rob Behrens emphasised this point in March 2024, reflecting in an interview with the Guardian on his retirement how 'there are serious issues of concern, especially about aspects of the culture of the NHS' [143]. Behrens pointed to the important role of leaders if there is to be necessary change in how patients and families are to be properly heard and heeded, and staff feel free to speak up about concerns:

> 'How can the "cover-up culture" be ended? "First of all, you have to recognise that it exists and secondly you have to make leaders accountable for how the culture operates," he says. Ministers, NHS bosses and the boards of NHS trusts need to be much more pro-active.' [143]

123. The NHS Staff Survey (conducted since 2003 and one of the largest workforce surveys in the world) is undertaken on an independent basis each year across the NHS and for the most recent one in 2023 (published in March 2024), approximately half of staff responded, which is a high rate by typical survey research standards. Dr David Oliver [144], reflecting on the NHS Staff Survey results in his British Medical Journal column noted that only 71% of staff who responded said that they would feel safe raising concerns with managers about unsafe clinical practice, and only 56% were confident that their organisation would act on this. Oliver pointed out that in an organisation with a duty of candour to report care failings 'lived experience doesn't

match the official ambitions and guidance' [144] a point that is supported by evidence from a national evaluation of Speaking Up Guardians [145].

124. The Guardian Service [146] likewise reported on the NHS Staff Survey results, pointing out that 'confidence levels are at a five-year low (71.3%) and there is a particular downward trend for medical and dental staff (down to 69.4% from a peak of 75.1% in 2021)'. The Guardian Service suggested it is time for a different approach, focusing less on 'speaking up' and more on how to enable constructive two-way dialogue about patient safety concerns.

125. Following the Francis Inquiry, NHS organisations were required to introduce structured ways in which staff can raise concerns or 'speak up' safely where they fear harm is being done to patients, staff or others. In 2014 Sir Robert Francis KC was commissioned to undertake a review of speaking up arrangements in the NHS. This revealed a mixed picture in terms of response to the original public inquiry recommendations about speaking up, and Francis set out what more needed to be done to properly embed safe, transparent, supportive and well-functioning processes for those needing to report and call out unprofessional and/or unsafe behaviours and practices [147]. Since 2016, 'freedom to speak up guardians' have been appointed in all NHS provider organisations, as part of wider arrangements for cultural sense-checking, patient safety and quality improvement. An annual report by the guardian must be made to the local NHS trust board [148].

126. **Research evidence on speaking up and being heard**. In a research study of whistle-blowing practices, Mannion and colleagues [149] pointed to the importance of organisations understanding and recognising that 'speaking up' will include various informal routes in addition to 'freedom to speak up' policies and guardians, and also to the fact that 'bellringing' is part of the spectrum of speaking up, this being the blowing of the whistle by outside agencies, patients, relatives or others. Another key finding from this study was that speaking up is but the first step in effective processes for raising concerns – it is just as important that the response dynamics are understood, trained for and supported. This has been described as the 'deaf effect' whereby senior managers may be reluctant to hear, accept and act on concerns raised by staff.

127. Another key issue with speaking up is that people from 'high power distance countries'[1] may find it unacceptable to speak up or criticise a superior [150]. Around 20% of people working in the NHS come from overseas, many from 'high power distance' countries and their national cultural socialisation may impede or stop them from raising concerns [150]. There are therefore important implications for induction and training of overseas staff in the NHS to feel able and supported to speak up when they see problems. Similarly, there needs to be training and support for overseas-qualified staff when they get to positions of authority to be able to 'listen down' to their subordinates who raise concerns [150]. Jones and Kelly [151] similarly emphasised the power of 'organisational silence' to resist efforts made by staff to raise concerns and likewise to implicitly support senior managers in failing to listen and respond.

128. Professor Russell Mannion and colleagues [149] made suggestions about how more effective whistleblowing might be enabled, including: establishing a formal agency to have oversight of speaking up; enabling whistle-blowers to apply for early-stage employment protection, and exploring the potential role of incentives to encourage the raising of concerns. The need for further attention to how speaking up *and listening and heeding* (my emphasis) can work to enhance safety culture in the NHS was underlined by Professor Alison Leary in a BMJ editorial about the Letby convictions [152]:

> 'The emphasis is also usually on the workforce speaking up, which in the current system requires courage, but perhaps the emphasis should be on listening. A safety officer in a large nuclear installation once told me that if people need courage to come to work, something has gone badly wrong.' [152]

129. Professor Graham Martin and colleagues [153] reported on research undertaken in four areas of England to explore progress with implementation of a range of policy measures (including freedom to speak up, the duty of candour and the fit and proper person test) intended to foster greater openness, transparency and candour about care quality and safety. The study revealed a mixed picture of progress in fostering a

[1] The concept of power distance was pioneered by Geert Hofstede et al (2010). The premise is that power distance defines the degree to which subordinates are willing to respect the hierarchy. In a high-power distance national society there is a large gap between those in power and those without.

more open culture of quality and safety and distilled four conditions considered necessary for change as set out in Box 8.

Authentic integration of openness into the mission of the organisation, making it an everyday concern. Having functional and effective administrative systems to support candour and speaking up. Leavening systems with flexibility and sensitivity as they are implemented. Embracing a spirit of continuous enquiry, learning and improvement, to avoid any sense of openness being a time-limited project. *Box 8: Conditions necessary for enabling a more open culture pf quality and safety (Martin et al, 2022)*

130. **Improving the culture for speaking up**. Progress has been made following the introduction of policies to encourage speaking up and whistleblowing in the NHS, along with the parallel progress with measures such as the duty of candour, fit and proper person test, CQC well-led framework and more structured arrangements for reporting on quality and safety failures [128]. The NHS Staff Survey results are however a bleak reminder of what still needs to be done to ensure a culture in the NHS that really enables and welcomes staff, patients and families to speak up about concerns about quality of care and be assured that they will be listened to, heard and actions taken [151]. The NHS Staff Survey consistently shows that people from a minority ethnic background are more fearful of speaking up, highlighting the need for more training and support to be given to these staff to ensure that they feel able and confident to raise concerns and to know that these will be heeded.

131. For further improvements to be made that will enable local organisational culture that encourages and supports speaking up, there is a need to focus on 'implementable' and practical actions. As Dr Dawn Goodwin concluded in her analysis of culture in public inquiries [124]:

    > 'The challenge lies in identifying and changing the aspects of practice (policies, people, resources, regulations, professional guidance and so forth) that anchor negative cultures in place, and allowing time for change to become visible.' [124, p9]

132. **Possible actions to improve speaking up**. Drawing on research evidence [149, 153] possible actions could include: clarifying in professional codes of conduct that

there is a formal duty to speak up about care concerns; including in any new code of conduct and formal standards for NHS managers that they have a duty to both speak up to those above them about matters of care quality and safety and to listen and respond to concerns raised by staff with them; explore the possibility of a national body to oversee speaking up or at least incorporate this role within another body such as the CQC; introduce formal measures to protect at an early stage staff who speak up; encourage bench-marking and sharing of good practice across NHS organisations, perhaps 'buddying' those with better staff survey and other data about effective speaking up with those who struggle to make progress; and providing tailored training and support for overseas-trained staff to empower them to speak up. Other possible actions include setting out in guidance about NHS staff health and wellbeing the ways in which local organisations will support those struggling as a result of speaking up, and articulating clear duties for managers and organisations to respond appropriately when concerns are raised with them [154].

133. What is clear is that 'sermonising' (see section of this statement on the reasons why inquiry recommendations work or not) about speaking up and culture will not bring about desired change [68]. There is a need instead for clear, practical and sometimes small steps that will help continue progress towards a more transparent NHS where staff feel psychologically safe to speak up, with confidence that they will be heard and heeded [6]. These also need to be evaluated effectively as they are introduced to help build robust evidence to inform policy in this area [156].

134. This is important not only for those clinicians, managers and others in the middle of NHS organisations, it is similarly vital that executive directors and senior clinicians feel supported to give 'bad news' upwards to central NHS bodies about possible or actual care risks, failings and incidents. The surrounding policy and professional cultures of local organisations (the 'cellar and orchard' in Mannion's terms [132]) need to be ready and able to hear when tough issues are shared with them, so that all NHS leaders and boards feel that they have clear permission to speak up and out.

The reasons why inquiry recommendations work or not

135. In this section, I suggest some ways in which NHS inquiry recommendations might be shaped, implemented and followed up, to lead to a greater chance of being adopted.

136. **Progress made in implementing inquiry recommendations**. There are many examples of inquiry recommendations that have served to improve the NHS, dating back to the establishment of the Health Advisory Service following the Ely Inquiry of 1969, and including more recently the founding of the CQC, the move to transparent reporting of clinician-level performance data, having fundamental standards of care, a duty of candour, Fit and Proper Person's Test and a formal duty on trusts to assure care quality and safety. There are however many instances where recommendations have not been enacted, or only after a significant lapse of time, this point having been made strongly in a 2024 report by the Expert Panel of the House of Commons Health and Social Care Committee in a study of government's responses to major inquiries that have focused on patient safety [157]. The Committee noted that in respect of leadership, training and patient safety: 'The other four recommendations in the areas of leadership, training and establishing a culture of safety we rated as 'requires improvement'. These recommendations included a code of ethics and conduct for managers and leaders; interventions on collaborative leadership and values; and creating safe organisational cultures where people feel safe to speak up.

137. Successfully implementing inquiry recommendations designed to improve organisational culture appears to have been more problematic, including the ways in which NHS staff are able to speak up or not – and critically, be heard. The duty of candour remains a work in progress and in need of research evidence to reveal and explain its apparently partial impact [129]. Furthermore, in a reflection of the lack of a formal code of conduct for NHS managers and leaders, the duty of candour does not yet fully apply to management and governance matters as clearly as it does for clinical practice [128]. This needs to be addressed if the NHS is to respond properly to Francis', Kark's, Kirkup's and others' recommendations for a more open, just and safe culture. Above all, the vexed matter of NHS management culture would seem to be as troubled as ever, with some struggling organisations too often denying evidence of failings in standards of care, and seemingly finding it impossible to hear and act upon the warnings sounded by patients, families and staff [128].

138. **The importance of implementable recommendations**. The careful crafting of implementable recommendations would help avoid what seems to be a tendency on the part of the NHS to develop lengthy action plans in response to an inquiry report, but then to let some recommendations slip off the radar in terms of importance for implementation. This reflects the 'policy fads and fashions' [67] instinct of the NHS to issue serial guidance, which does not in fact have formal legal status [158] and move

on too quickly from the tough work of funding and implementing multiple recommendations that could lead to change.

139. There is learning to be gained from Donna Ockenden's approach to recommendations in the interim and final reports of her inquiry into the maternity care failings in Shrewsbury and Telford [115,116]. In both reports, she set out local (for the Shrewsbury and Telford Hospital NHS Trust) and national (for all NHS maternity services) actions, making it clear that she expected work on these to start, in the case of the interim report, immediately and not to await the full and final inquiry report. This did indeed happen and 'Ockenden actions' quickly formed part of the maternity improvement work and priorities of NHS England, local maternity systems, and provider trusts, with structured data collection and reporting processes in place [159].

140. **Monitoring and following up on actions in response to inquiry recommendations**. An assessment of progress in implementing and sustaining recommendations from NHS inquiries (using the Francis Inquiry as the main case study) made by Ruth Thorlby and me for a Reading University Law School Symposium [128] in 2022 noted that despite major sums of money being invested in establishing and running public inquiries, there is not yet a systematic approach in place to track and assure full and sustained actions in response to inquiry recommendations. This was also examined by the Institute for Government in a report on how public inquiries can lead to change [160]. A further consideration to be made here is how far there is the will and capacity within the NHS to implement the (often many) recommendations made by inquiries. As noted earlier in the evidence about serial issuing of policy guidance, the NHS is often much better at issuing guidance than reallocating resource and management capacity to implement and sustain recommendations.

141. Public inquiries bring legal expertise, analysis and challenge to bear upon a very large, complex and centrally managed public sector organisation with a powerful, often impenetrable and sometimes defensive culture. Inquiry evidence and reports set out in full public gaze the worst that can happen within NHS health care, the reasons for these failings, and many suggestions about how they might be remedied. Whilst it is often a judge or senior barrister who is asked by government to chair a public inquiry – because of the perception of independence, gravitas and inquisitorial skills - the clash of differing legal and NHS management cultures and ways of

working may be one reason for why the NHS (and indeed health policy makers) struggle to accept and act upon many recommendations made [128, 160]. This is unlikely to be deliberate or conscious, but instead due to fundamental differences in underlying professional cultures and assumptions.

142. Analysis of public inquiries has often argued that politicians use this approach to be 'seen to be doing something' and then too often move on or cannot fund and/or implement what is needed over the longer term [161]. Nick Timmins, in an article 'Seven Things to Consider Before Setting up a Public Inquiry' included 'think, even at the beginning about follow up' as one of the considerations, suggesting that this might include formal select committee scrutiny, a reconvening of the inquiry team at a certain point in time, or attention to having tightly focused recommendations with a greater chance of being implemented [162].

143. Others have concurred with Timmins that part of the problem lies with the nature of the recommendations made by inquiries [155]. Professor Martin Powell has analysed the recommendations from three major inquiries, to explore whether the recommendations had both clear actions and agents to carry out those actions [68]. In the case of the Francis inquiry, Powell concluded that 41% of the 290 recommendations had an explicit action to be taken by a specific body (or joint bodies) [68]. He also noted that inquiry recommendations tend to fall into three main categories: sticks/penalties; carrots/incentives and sermons/exhortations to change [68]. A further consideration to be made about recommendations is what Julia Unwin has asserted as the need for policy proposals to speak to the 'relational' as well as 'rational' lexicon of managers and leaders [163], winning hearts and minds and connecting with purpose, as well as being technically and administratively appropriate.

144. Even when there are specific, actionable recommendations, accepted by government and the NHS there is a need for more systematic and formal accountability processes to track progress with public inquiry recommendations [128, 160]. Similar conclusions have been drawn from scrutiny of public inquiries outside health, such as that by the National Audit Office [164]. In the case of the NHS, this follow-up scrutiny might include a requirement for the Department of Health and Social Care and NHS England (and other bodies relevant to the specific inquiry recommendations) to report to the Health and Social Care Committee of the House of Commons on a regular basis. Alongside this, there needs to be an expectation that DHSC and NHSE will

provide funding and expertise to support implementation of inquiry recommendations, including the change management required.

145. The Institute of Government, in their report 'How Public Inquiries can lead to change' noted the significant changes made in response to some inquiries, including the move towards much greater oversight of healthcare professionals [160]. They go on however to argue that there is a pressing need in future for 'implementing change and preventing recurrence must be put at the heart of our system of public inquiries' [160, p32]. They suggest that Parliament's Liaison Committee be required to scrutinise the implementation of inquiry findings, interim reports of inquiries be published as soon as possible to set out any immediate necessary changes (echoing the approach taken by Donna Ockenden in Shrewsbury and Telford), expert seminars be used by inquiries to help shape recommendations (as in Bristol and Mid-Staffordshire), and that government should establish a permanent inquiries unit within the Cabinet Office [160].

146. Research and evaluation could be used to greater effect in following up and understanding responses made to public inquiry recommendations and what has helped or hindered progress. Given the very significant investment that is made in a public inquiry it is striking that there has not been more attention to putting in place alongside-evaluation of the implementation (or not) of findings. Following the Francis Inquiry, the Department of Health Policy Research Programme commissioned a suite of studies, but I believe this was something of an exception to the usual approach taken with NHS inquiries. And even in this case, more could arguably have been made of the findings from these studies, perhaps commissioning an overarching synthesis to draw out learning and feed this into future guidance and policy on the conduct of inquiries.

Conclusions

147. Drawing on the analysis set out in this statement of evidence, I set out here my conclusions using the seven core themes of this statement.

148. **Oversight and regulation of NHS management and leadership**. There has long been a need for a formal code of conduct for NHS managers and leaders to set out the ethical underpinning of their role and provide them with a vital point of reference against which to calibrate their decisions and behaviour in what are complex and

sometimes contested jobs. A new code could build on the NHS Code of Conduct for NHS Managers developed in 2002 and yet not implemented in a sustained or mandated manner. To this could be added the Nolan Principles of Public Life and Professor Don Berwick's principles for leading a high-quality health system developed following the Francis Inquiry. Many NHS managers appear to be ready to have such a code and thus more formally professionalise their role, provide equity with clinical professionals, and empower and protect them always to act and speak up for patients and staff. This should be enshrined in employment contracts and used as the basis for recruitment, appraisal and some form of professional revalidation. Oversight of the operation of the code needs to reside in a national body, but there is probably not a need for a specific new organisation.

149. **Leadership qualities and behaviours for NHS senior managers.** There is a need for a single set of leadership standards, that will be regularly reviewed and updated, taking the place of the serial issuing of often duplicative policy proposals for management and leadership behaviours. The GMC and FMLM approach to clinical leadership and management standards, with linked accreditation of training and development, offers insights into how this might work. There is a careful balance to be struck between over-specification by say NHS England or DHSC, and how these standards would be applied within local organisations and integrated care systems. These standards need to include the primary responsibility for care quality and safety, and the assurance of psychological safety for all staff and leaders in the organisation. There is a need to explore how NHS managers and leaders might have a formal professional body to which they could belong and gain support and development, and which could advocate for them in policy and practice circles. This could perhaps build on the IHSCM and assume a stronger peer support and accrediting role as with the former Institute of Health Services Management in the 1980s and 1990s.

150. **The training and development of NHS managers and leaders.** The training and development of senior NHS managers and leaders, and its funding, continues to be too much left to local and personal decision, with no formal requirement for training or continuous professional development (CPD) at any point of management and leadership careers. Along with a formal code of conduct for NHS managers, there is a need to articulate a single and mandated clear and concise set of leadership qualities and behaviours, complementary to those developed by the GMC and FMLM for clinicians in hybrid management roles. Regulation of managers must go hand in

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hand with mandated and fully funded professional training and development to meet those qualities and behaviours. Standards in a code of conduct can then be used for recruitment of people to senior management and leadership roles (including non-executive directors) and for design, provision and oversight of training and CPD, linked into annual appraisals and revalidation. This could in turn help address the current inequity in access to and funding for training and development of managers.

151. **The role of NHS boards in quality and safety governance.** NHS bodies rely on collective leadership which is why the board is key, being responsible for patient safety and quality alongside financial and other dimensions of organisational performance. The chair leads the board and in partnership with the chief executive is responsible for the culture in their organisation which in turn is shaped in part by how the NHS is led, including the performance management regime and behaviours of the wider policy and management system. The buck does, however, stop with the trust board which relies particularly on the chair to ensure good governance by a board with the right skills, experience and continuing professional development. And given the 'mosaic' of local organisational cultures within the NHS, the board has a similarly key role in setting, supporting and monitoring its own local culture and the extent to which it is psychologically safe for staff and patients.

152. The effectiveness of patient safety governance and management structures appears to vary too much between local organisations, reflecting the federated nature of NHS trusts. There is much good practice in how clinical governance works within NHS trusts, and its inspection by the CQC forms a core part of the well-led framework, as does the effectiveness of staff's freedom to speak up. There is a need for a national approach to the recruitment, selection and training of non-executive directors and chairs. Clinical governance needs to operate on a 'problem-sensing' and not 'comfort-seeking' basis [113]. A non-executive director-led board quality and safety committee needs to be mandated for all trusts, including its membership, purpose and scope, and guidance about how it should operate. Buddying of organisations who can learn from one another about good clinical and wider governance practice would offer a further route for assuring effective oversight of care quality and safety. The role of the Council of Governors of a foundation trust in respect of quality and safety matters needs to be clarified and strengthened. Engagement with and leadership and assurance of effective clinical governance should be a core part of any new code of conduct for NHS managers.

153. **The critical yet complex role of culture.** There is clearly a problem in some local organisations whereby staff do not feel sufficiently safe to speak up about concerns, this having its roots in the complex and layered nature of organisational culture in teams, departments, services and at overall organisation level. This is not as simple as one organisation has a healthy culture and another one not. There is a very important issue for the NHS to address about its surrounding or wider system management culture, which is too often reported as oppressive, bullying or overly focused on performance management, and not wanting 'noise' from local organisations.

154. Addressing this wider culture which is not perceived to be sufficiently psychologically safe will be a complex and longer-term challenge. Professionalising, training and regularly developing NHS managers and leaders to regard care quality and safety as a profoundly primary duty could help. Along with formal CPD, the establishment of a national professional and accrediting body for NHS managers could help NHS management become a recognised profession with necessary independence from the 'centre' and feeling able to report concerns with confidence, something that is merited by its critically important role. There is also arguably more that organisations could do and evidence in respect of their work to develop local learning cultures and systems as suggested in the recommendations of the 2013 Berwick Review.

155. **Openness, speaking up, hearing and responding.** This is profoundly dependent on the culture of local NHS organisations, including the example set by their board and directors, and the effectiveness of their clinical governance arrangements from ward to board. The variable nature of how such communication works or not is evident from NHS Staff Survey results and this mixed picture is unacceptable to the communities served and to the staff who work in the system. Actions to address this could include: more sharing of good practice and pairing up of high performers with those who struggle in this area; a stronger legislative framework to protect whistleblowers; a well-functioning code of conduct for managers and leaders of all levels to support them in feeling able to speak up to higher levels, and respond to what they hear; clear and statutory guidance to NHS trusts about clinical governance, safety reporting, and the operation of quality committees and governance; and a requirement for executive and non-executive directors to have training in this area. There is also a need to enact the recommendation made by the Francis Inquiry that the duty of candour apply to senior managers and board members about their management work and reporting, as well as to clinicians in their patient care. There is

a need for more policy, research and training attention to hearing and responding to concerns, as a counterbalance to the current emphasis on speaking up.

156. **The reasons why inquiry recommendations work or not.** It is important that inquiry recommendations are implementable with clarity of who can enact them, how and with what measures in place to assure this. Inquiry expert seminars could help with the crafting and testing of evidence-based recommendations. There is also a need for systematic and formal follow up of the responses made by national and local NHS bodies to inquiry recommendations, including the possibility of an inquiry reconvening to take stock of what has happened or not, and an established long-term role for select committee or Liaison Committee scrutiny. The National Institute for Health and Care Research could also play a greater role in commissioning, disseminating and curating research evidence related inquiry recommendations, including about culture, governance, speaking up and patient safety, working closely with any new professional body for NHS leaders and managers, and the membership organisations that represent NHS trusts (NHS Providers and the NHS Confederation).

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.

Personal Data

Signed: ____ ____________________________

Dated: ___7 June 2024____________________________

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