Witness Name: [XXXX]
Statement No.: [XXXX]
Exhibits: [XXXX]
Dated: [XXXX]

THIRLWALL INQUIRY

WITNESS STATEMENT OF DR JENNIFER DIXON DBE, CHIEF EXECUTIVE, THE HEALTH FOUNDATION

I, Jennifer Dixon, will say as follows: -

Introduction and career history

1. I am chief executive of the Health Foundation, a role I have held since 2013. Previously I was chief executive at the Nuffield Trust from 2008 to 2013, director of policy at The King's Fund and policy advisor to the chief executive of the National Health Service between 1998 and 2000. I trained in medicine and practised mainly in paediatric medicine. I hold a master's in public health and a PhD in health services research from the London School of Hygiene and Tropical Medicine.

2. I have served as a non-executive board member of the UK Health Security Agency since April 2022. I have previously served as a non-executive on the boards of the Health Care Commission (2004-2009), the Audit Commission (2003-2012) and the Care Quality Commission (CQC) (2013-2016). I have led two national inquiries for government: on setting published ratings of care quality in NHS and social care providers in England (2013); and on setting of ratings for general practices (2015).

3. The Health Foundation is an independent charity committed to bringing about better health and health care for people in the UK. Our aim is a healthier population, supported by high quality health care that can be equitably accessed. We learn what works to make people's lives healthier and improve the health care system. From giving grants to those working at the front line, to carrying out research and policy analysis, we shine a light on how to make successful change happen. The Health Foundation works across the UK, but the majority of the material covered in this statement relates to health and care services in England. A short history of the Health Foundation, published in November 2022, is available on our website.

4. The Foundation is accountable to our independent board of trustees and the Charity Commission. Our endowment – currently valued at over I&S – funds our charitable activities and means we do not need to fundraise to generate income. This model is essential to our independence and ability to plan and fund work for the longer term.

5. We seek to apply an equity lens to our work where possible and highlight where parts of our population are at greater risk of ill health or are less well served by the health and care system. Beyond this, we do not represent, support or advocate for the interests of any specific groups on an ongoing basis. The Foundation is independent from government and not linked to any political party. We have no donors, supporters or members. The Foundation receives a small amount of funding from grants, commissions and from our co-ownership of the *BMJ Quality & Safety* journal and grants from other organisations. Our website provides details of our key partnerships – including those with public bodies operating at arm's length from government such as the Q Community and the Improvement Analytics Unit.

Sectoral challenges

6. I am asked the extent to which wider systemic or sectoral issues within the NHS have an impact on patient safety and the quality of health care – with a focus on neonatal care. During the period being examined by the inquiry (2012 onwards), the NHS in England was facing a complex array of pressures which are likely to have cumulatively impacted the extent to which local services were able to deliver consistently high-quality care. These were a result of developments in health care needs, operational challenges and national policy choices. Below I set out some of the important trends which may have negatively impacted care quality.

Funding and public services

7. In the years after 2010, government policy prioritised closing the deficit between tax receipts and public expenditure, with the bulk of the adjustment made by controlling public expenditure (rather than raising taxes). As a result, in the decade prior to 2019/20, day-to-day public service spending fell by 13% per person in real terms (Exhibit JD/1 [INQ0101383]). The NHS was partly protected – seeing real-terms funding increases in day-to-day spending over the period – with the effect that outside of health care, real-terms public service spending was cut by 25% per person between 2009/10 and 2019/20 (Exhibit JD/1 INQ0101383). These policy choices negatively affected the social and economic conditions in which people live and eroded the resilience of a range of public services.

While there may have been some initial scope for driving efficiency in the public sector, throughout the 2010s this became more challenging and gradually a range of public services – education, criminal justice, adult social care and health services – showed signs of eroding the scope or quality of services as efficiencies were gradually unable to close gaps between demand for services and available resources (Exhibit JD/2 [INQ0101394]).

NHS funding and capacity

8. During the austerity period the NHS in England was partially financially protected compared to other public services, receiving real-terms funding increases of around 1.4% per year from 2009/10 to 2018/19 (Exhibit JD/3 INQ0101399. While favourable compared to other parts of the public sector, this was unusually austere compared to historic NHS funding growth of 3.6% per year in real terms between 1949/50 and 2018/19 (Exhibit JD/3 INQ0101399. In international comparisons of health spending per person, the UK persistently lagged other high-income countries. By 2019 health care funding per head in the UK (£2,647) was substantially below that in similar advanced economies – like France (£3,308) and Germany (£4,131) (Exhibit JD/4 INQ0101400. One effect of constrained funding was to limit the development of NHS capacity in relation to growing population health needs. By 2019, the NHS in England was operating with roughly 2 hospital beds per 1,000 people, while France ran 3 beds per 1,000 people and Germany 6 beds per 1,000 (Exhibit JD/5 INQ0101401. The NHS in England also used its hospital bed stock more intensively than many other health systems, with higher levels of overnight bed occupancy – approaching 90% nationally – and shorter average length of stay (Exhibit JD/5 INQ0101401

NHS workforce shortages

9. Workforce supply is a long-standing challenge for the NHS. Indeed, over the last decade workforce shortages have arguably been the pre-eminent strategic challenge facing health services. Prior to 2020, NHS trusts were short of roughly 100,000 staff on full time basis (or around one in eleven posts). Alongside, social care services were missing around 120,000 staff (Exhibit JD/6 INQ0101402. Over the last decade, national policymakers have outlined a number of aspirations to boost workforce supply including some high-profile political commitments such as recruiting 50,000 more nurses and 6,000 more GPs, but a comprehensive workforce plan for the NHS was not published until 2023 (and social care services still operate without a comparable plan for the workforce) (Exhibit JD/7 INQ0101403. The effects of these long-standing shortages were bad for existing staff.

Evidence (eg via the NHS Staff Survey) pointed to poor workplace experience, widespread experience of excessive workloads, staff stress and high levels of turnover. For example, in 2019 less than one third of respondents to the NHS Staff Survey (32.3%) reported their organisation had enough staff to enable them to do their job properly (Exhibit JD/8 INQ0101404. These operational conditions (and other challenges within the NHS which contribute to a poor working environment for staff – considered further below) are not conducive to delivering consistently safe and high-quality care.

Health and care planning and delivery arrangements

10. The health and care system went through large scale changes during the 2010s which, although they did not directly change NHS trusts' operating parameters had major implications for the national and local systems of which they are part. The Health and Social Care Act 2012 led to a reorganisation of national structures, created a new configuration of local commissioning agencies and redrew roles and responsibilities among national bodies, including creating a number of new national organisations. Over subsequent years there was further organisational change within the NHS as national bodies consolidated, regional teams were reorganised and many local commissioning groups worked together or formally merged. This led to a process of ongoing leadership churn, weakened institutional memory and instability in local relationships. Meantime, adult social care services in England operated in a framework which lacked robust national leadership and policy coordination. Governance and commissioning responsibilities sit with roughly 150 local authorities, with local democratic mandates and accountabilities, and services were delivered by a variety of care organisations (roughly 18,500 providers operating in England).

Data infrastructure and capabilities

11. The health and care system in England operated with an incomplete and fallible architecture for data collection, aggregation, storage and analysis. This included aspects of data providing insight into care quality, which did not consistently enable national policy discussions to be informed by high-quality data. These deficiencies were related to the UK's record on capital expenditure in health care – long-term investments in things like buildings, equipment and data and ICT infrastructure. Over an extended period, the UK government has spent materially less than similar countries on capital projects. For example, between 2010 and 2019, had the UK matched EU14 countries' average level of capital investment (as a share of GDP), an additional £33bn would have been spent on health capital (Exhibit JD/9 INQ0101405. Despite these long-term shortfalls in capital

funding, as a nationally funded and organised system, the NHS in England has some real data strengths, eg in understanding overall national hospital capacity and utilisation. Yet in some other service areas there were material challenges in relation to data availability and quality. Additionally, gaps in data infrastructure were compounded by deficiencies in skills, knowledge and understanding of how to interpret and analyse data in ways which generated useful insight for policymaking and supported work to improve care quality.

Adult social care reform and operational pressures

12. Adult social care services support people with tasks of daily living, particularly people with physical disabilities, learning disabilities or physical and mental illnesses. Unlike the NHS, publicly funded social care services in England are subject to strict needs and means testing. Social care influences people's ability to live independently, their likelihood of needing to access health services, and plays a role in providing support to people leaving hospital after a spell of inpatient care. As such, the health service's ability to operate effectively, and deliver safe high-quality care, is intrinsically linked to the fortunes of social care services.

13. The adult social care sector in England has experienced a sustained period of challenges related to changes in demand for care, funding and workforce. Despite growing need for care, public funding in England was under downward pressure through much of the 2010s, falling from an average of £346 per person in 2010/11 to £324 in 2017/18 – substantially below per person spending levels in Scotland and Wales (Exhibit JD/10 INQ0101384). In this context, local authorities tightened local eligibility meaning many people going without care and support from which they would benefit (or relying increasingly on informal care from family and friends). Widespread vacancies and high rates of turnover characterise much of the social care workforce; by the end of the 2010s, the social care sector was operating with an estimated 110,000 vacancies. And low pay has been a long-standing issue in social care, with nearly 1 in 5 (18.5%) residential care workers in the UK living in poverty from 2017/18 to 2019/20 (Exhibit JD/11 INQ0101385).

14. Over this period, successive governments pledged – and in some cases legislated – to reform adult social care to improve the quality of care services and expand the degree of social protection offered, but substantive reform was not delivered. The effect is that

publicly-funded social care is a gap in the welfare state – a limited safety net, offering support only to those with the highest support needs and lowest financial means.

Effectiveness of current governance and management arrangements for patient safety and quality

15. I am asked if the inquiry should have concerns about the effectiveness of current governance and management structures, or cultures within hospitals, in keeping neonatal babies in hospital safe and ensuring the quality of their care. And if so, what changes should be made – nationally or locally – to improve the quality of care and patient safety? Below I briefly outline my understanding of the key elements of the current national policy architecture for patient safety and then outline some reflections on the tensions discernible in NHS policy in relation to embedding an effective national governance model which can reliably promote safe and high-quality care.

Current national policy and delivery arrangements for care quality

16. In the years since 2012, the national policy arrangements to promote, support and monitor patient safety across the NHS in England have developed substantially. Today, NHS England (NHSE) provides national policy leadership around the patient safety agenda, most recently through its national patient safety strategy (first published in 2019 and refreshed in 2021). The strategy sets out an aspiration to drive sustained improvements in patient safety by fostering a culture focused on safety and embedding a robust system for monitoring patient safety. It aims to save 1,000 lives per year and approximately £100m in direct care costs annually. A number of workstreams are being progressed under the auspices of the patient safety strategy.

17. One aspect of the national patient safety strategy is to work with and through patient safety collaboratives, regionally based multi-organisation programmes of work focused on improving health care safety. Collaboratives were established in 2014, hosted by academic health science networks (subsequently health innovation networks), and engaged clinicians and multi-professional teams from across local organisations to engage in structured improvement development work around safety-relevant topics. Collaboratives had relative freedom to define their priorities and operating model locally. While a focus on supporting local collaboration and learning around improvement disciplines may be welcome in principle, a subsequent review acknowledged a lack of evidence to quantitatively assess the impacts of collaboratives (Exhibit JD/12 [INQ0101386].

The latest national patient safety strategy sees collaboratives as playing a role locally in supporting and joining up adjacent strands of safety focused work.

18. Another aspect of the patient safety strategy is a change to how trusts report on, and learn from, patient safety incidents. Since 2015, NHSE maintained a serious incidents framework which defined how trusts should record, review and learn from serious incidents. From 2022, trusts and foundation trusts have been transitioning from that to a patient safety incident response framework (PSIRF) which is introduces a new set of expectations around how trusts monitor, review and learn from patient safety incidents. The PSIRF approach is intended to provide a more flexible model for responding to patient safety incidents depending on the context, and foregrounds the importance of engaging compassionately with patients and service users, creating a supportive environment for staff and a focus on capturing and harnessing learning.

19. Since 2017, health services in England have been overseen by the Healthcare Safety Investigations Branch (HSIB), which in 2023 became the Health Services Safety Investigations Body (HSSIB), an independent non-departmental public body. The HSSIB has a remit to conduct independent investigations into patient safety concerns, identify learnings and share those learnings with a view to supporting improvements across the health service. HSSIB's investigations do not aim to establish liability, and focus mainly on contributory factors and aim to reduce the likelihood of future patient safety incidents. It also provides training and education services for health professionals. The HSIB had a remit to conduct investigations into safety incidents which occurred in maternity and neonatal services, but following legislative changes in 2022, responsibility for hosting the programme of maternity investigations transferred to CQC.

20. A number of other national bodies also play a role in promoting safety and quality of health services in England. The Medicines and Healthcare products Regulatory Agency (MHRA) regulates medicines and medical devices, including vis-à-vis their impact on patient safety and responds to any suspected incidents linked to products or devices. NICE develops evidence-based quality standards for health and care services and shares other information to support the delivery of high-quality services. CQC, alongside hosting the maternity safety investigations programme, has a role in oversight of services around quality and safety – monitoring data and insight, responding to developments which suggest quality or safety issues are crystallising, inspecting services as appropriate, and taking regulatory action against providers where needed.

21. Several aspects of the current national policy agenda and delivery infrastructure around patient safety are comparatively new – eg the latest national patient safety strategy, the patient safety incident reporting framework, a new statutory footing for the HSSIB – which limits the extent to which is it possible to draw evidence-based conclusions on its impact. But below I point to some of the long-standing tensions inherent in designing a governance and management model for patient safety and care quality in England, which may help to inform the inquiry's view of the strengths and weaknesses of the current regime.

Lack of a clear national strategy focused on care quality

22. In 2013, the final report of the Francis Inquiry into the failings of care at Mid Staffordshire NHS Foundation Trust between 2005 and 2008 was published. It set out how, among other things, a combination of sectoral pressures contributed to an environment in which poor quality care was delivered at the trust (Exhibit JD/13 INQ0101387). The subsequent national policy response exemplifies some of the challenges of maintaining a strategic focus on safety alongside other priorities. On one hand, the government commissioned a national review of how to embed quality and safety in the NHS, led by Don Berwick, which made some important recommendations (explored further below). Yet on the other hand, over the following years the nearest thing to a national strategy for the NHS in England was the *NHS five year forward view* (published in October 2014). This set a direction of travel for the system, and to an extent it did include an emphasis on care quality (closing the 'care and quality gap' as it termed the challenge), but – despite being developed and published only relatively shortly after the final Francis report – it did not include a fully worked through articulation of a delivery methodology for improving care quality across England. Research with local staff and operational leaders working in NHS services during the period after the *Five year forward view* was published found that they experienced the national commitment to improve quality was weak compared with other national priorities on operational and financial performance (Exhibit JD/14 INQ0101388

23. This relative lack of emphasis on care quality in the *Five year forward view* is symptomatic of a longer-term tendency in national policy in England. Some previous national strategies for the NHS in England have sought to foreground care quality as an organising principle for local services – eg *High quality care for all* published in 2008. But, in practice, the quality agenda has struggled for consistent prominence alongside other national priorities like timely access to care and financial control of NHS budgets.

Fragmented national leadership for care quality and patient safety

24. The health and care landscape in England is led by a number of bodies with national remits for different elements of policy making and oversight relevant to safety and care quality – and has been subject to substantial change over the last decade. In 2013, when then Francis Inquiry reported, the national tier of NHS policymaking included the Department of Health (which subsequently became the Department of Health and Social Care – DHSC), NHSE, the Trust Development Authority (TDA), Monitor, CQC, the National Institute for Health and Care Excellence (NICE), and Health Education England (HEE). Over subsequent years there has been a trend towards consolidation of national bodies – for instance with the functions of Monitor, the TDA and HEE all being gradually folded into NHSE – but this process has happened in an iterative rather than strategic fashion. One effect of this crowded national policy landscape has been to make coordination at national level more complex, and to allow national bodies to simultaneously progress a range of related but distinct priorities and initiatives intended to improve care quality.

25. In the wake of the Francis Inquiry there was a range of initiatives promulgated by government and national bodies under the auspices of improving care quality – which local services were responsible for trying to implement locally. While this may have been well intentioned, this array of activity at national level – described by some analysts as policy 'hyperactivity' – suffered from at least two drawbacks which diluted any impacts: i) the cumulative volume of activity and agendas meant each initiative struggled for local focus, longevity and resource; and ii) the variety of approaches advanced by government and national bodies sometimes exhibited different conceptualisations of how to improve care quality (Exhibit JD/15 INQ0101389.

National focus on regulation rather than improvement

26. Notwithstanding the fact that other priorities in the *Five year forward view* were often perceived to be of greater importance than quality, the years following the Francis report did see a range of national initiatives intended to improve care quality and safety in the NHS. Some local impacts were seen from these policy agendas. Research with acute trust boards in the years after Francis reported found many trusts taking steps to better manage and learn from patient complaints and increase staffing levels, particularly nursing capacity, with a view to bolstering quality and safety (Exhibit JD/16 INQ0101390.

27. However, the way in which national policy in England has sought to bolster care quality has been a recurring issue. Namely, looking across the array of activity focused on quality from 2010 onwards (and particularly post 2013), it is clear that policymakers have disproportionately focused on establishing regimes for oversight, regulation and inspection of local services as a means to improve care. Regulation and oversight can play a role, but this focus has come at the expense of an understanding of, and proportionate support for, developing improvement skills and capabilities in local health services as a route to delivering sustainable improvements in care quality and safety.

Providers and services face multiple overlapping local accountabilities for care quality

28. The structure of the NHS in England includes a range of checks and balances which seek to ensure a number of accountabilities for different aspects of care at local level. In theory, these arrangements for constructive challenge built into the system should provide ongoing impetus to improve care. However, in practice these arrangements often struggled to generate this virtuous cycle. NHS trusts and foundation trusts can be held to account by integrated care boards (ICBs) (and their predecessors, clinical commissioning groups (CCGs)) as local commissioners of services, NHSE as the national oversight body, CQC as the regulator inspecting the quality of services, and they are subject to other sources of scrutiny (and in practice the DHSC could also exert influence on trusts' decision-making in some circumstances). In addition, health care professionals working in NHS services face a range of regulatory interfaces from professional regulators, professional associations, royal colleges and other organisations (Exhibit JD/17 INQ0101391). This includes oversight and investigation functions sitting with independent regulators, such as the General Medical Council and the Nursing and Midwifery Council, and input from professionally focused royal colleges setting standards, assessing care, and providing training and development activities. This complex lattice of organisations seeking to understand, monitor and influence care quality locally can make it difficult for policy agendas to mesh effectively and risks a lack of coherence across agendas. And the number of organisations and agendas which provider organisations are expected to act on risks distraction, incoherence and a lack of sustained focus on individual initiatives.

Some NHS services, eg primary care, lack access to functions to support improvement

29. As the national body setting NHS strategy, overseeing trusts' performance and commissioning some services directly, NHSE (and its regional teams) maintains a particular relationship with NHS trusts and foundation trusts – including a regular

dialogue about all aspects of performance, ensuring accountability and offering a suite of support functions. Primary care services – general practice, community pharmacy, dentistry (which deliver the great bulk of day-to-day patient contacts in the NHS) – operate in a different set of institutional arrangements. As contractor services, they are in a less directly managerial relationship with the national body. Instead of maintaining a regular dialogue with NHSE and accessing support from that body, they are largely overseen by local commissioners (currently ICBs). Local commissioners often lack dedicated support functions for improving safety and care quality in primary care and, primary care providers are mainly small independent entities which generally have less organisational capacity to bring to bear on these agendas. This creates an inequality in the extent to which local services are equipped to progress national agendas around care quality and safety.

How to change and improve governance for care quality

30. It is important to acknowledge that arrangements in place for overseeing and governing care quality in the NHS in England have evolved since the period when crimes were committed by Lucy Letby at the Countess of Chester NHS Foundation Trust. However, it remains the case that today there are instances of patient harm and failures of care within NHS services. This suggests there is more to be done to embed truly effective governance for safety and care quality.

31. Creating an operating environment which embeds care quality and patient safety as a strategic priority will be a long-term agenda and will require sustained political and policy leadership, as well as a coherent set of administrative measures spanning, national, regional and local levels. It will need long-term resourcing, and durable management and programme delivery arrangements. In constructing arrangements to embed this, a number of elements need to be in place together to stand the best chance of creating an impactful national agenda to improve care quality (Exhibit JD/18 INQ0101392: i) a shared view of care quality; ii) a shared set of quality goals, and a common operational definition of care quality; iii) a single point of national leadership for quality; iv) a group of core quality metrics which are anchored in staff and services' operational reality and enjoy professional support; v) a shared understanding of the relationship between quality and cost; vi) joined up regional and local leadership for quality (including ensuring support and capability building for service leaders focused on how leaders can play a role in shaping quality and safety); and vii) consistency of purpose from national leaders and policymakers to embed quality and safety in all national priorities in the future.

NHS culture around patient safety

32. I am asked if I consider that there is a culture in the NHS that inhibits members of staff from raising concerns about quality of care. And if I consider that there are ways to improve (i) the awareness of how to report concerns and (ii) the effectiveness of raising concerns. And if so, what improvements I would suggest.

33. Developing an operating culture in health care services that centres the importance of patient safety is a multi-faceted challenge. A readiness among staff to speak up and report concerns about care quality is an important, but far from sufficient, condition for services to truly be manifesting a robust patient safety culture. A range of different definitions of patient safety culture exist; they commonly include several features, including: effective leadership teams and capabilities; promoting an ethic whereby staff work in multidisciplinary teams to deliver care; a commitment to evidence-based health care practice; prioritising effective communication between staff and patients; continuous learning among staff and teams; and patient centred ways of working (Exhibit JD/19 [INQ0101393]).

34. The NHS Staff Survey, which is conducted annually and gathers insights from hundreds of thousands of staff working in NHS services, provides valuable insight into the extent to which staff experience some of these operating conditions. The most recent figures from 2023 indicate a mixed picture regarding staff's sense of psychological safety around raising concerns (Exhibit JD/20 [INQ0101395]. Roughly four in five (78.3%) registered nurses and midwives reported feeling secure to raise concerns about unsafe clinical practice. This rate has remained fairly stable over recent years, with 79.5% of nurses and midwives reporting they had confidence to raise concerns in 2019. Among some other clinical professional groups, however, rates of confidence are lower: seven in ten medical and dental staff (69.4%) reported feeling similarly safe (down six percentage points since 2021), and only 66.3% of ambulance staff would feel secure raising a concern about unsafe clinical practice. These figures suggest there is work to do to truly ensure frontline NHS staff feel able to raise concerns about care quality and patient safety.

35. Staff survey data also points to serious concerns that current operational pressures on NHS services are not conducive to delivering consistently safe, high-quality care. In 2023 only around a third (32.4%) of respondents said that their organisation employs enough staff to enable them to do their job properly. Nearly a third of respondents (30.4%)

indicated that they 'often' or 'always' experience burn-out due to the demands of their work; and over four in ten staff (41.7%) report feeling unwell as a result of work-related stress. These findings point to the fact that well intentioned policy initiatives and measures focused on patient safety occur within a broader context, and today the operating environment for NHS staff is hugely pressurised, with a growing mismatch between demand and capacity.

Recommendations from past inquiries relevant to patient safety

36. I am asked if I consider that recommendations made from previous inquiries have worked to improve the NHS. And if not, what factors have contributed to them not being effective in a health care context? Below I outline a number of reflections regarding the quality of patient care being delivered today and the challenges of translating good intentions into real improvements in care quality and patient safety.

37. Establishing a holistic view of patient safety and care quality is not easy. Quality and safety are multifaceted, vary across services and insight into them is often inherently imperfect. Recognising this limitation, contemporary analyses of patient safety in the NHS in England suggest a mixed picture: some improvement on some indicators of patient safety, some stasis, some service areas which remain poorly illuminated by national data and insight and at risk of poor-quality care being missed, and the continued fact that every year many patients experience avoidable harm while accessing NHS services.

38. Over the last decade, a range of initiatives have been implemented with an intent to improve patient safety and care quality – and the assessment offered above suggests some progress has been made. Yet despite some welcome progress, it remains the case that avoidable harm is occurring within the NHS. This disjuncture between the body of evidence about how to ensure high-quality care and the realities of every-day practice – has been referred to as an 'implementation gap' (Exhibit JD/21 INQ0101396). A number of factors – outlined below – may be contributing to this delivery challenge.

Evaluation of patient safety initiatives is complex in a changing policy environment

39. There have been a number of inquiries relevant to patient safety over the last decade – spanning statutory national inquiries, and more locally focused inquiries exploring services in particular trusts, geographies and services. Some recommendations made by

these inquiries have been taken forward and put into practice. For instance, the Francis Inquiry recommended a statutory duty of candour be introduced for all health and care providers, which places a general duty on provider organisations to be open and transparent with patients and service users. The government subsequently legislated for that in 2014. However, reaching clear conclusions about the extent to which changes of this kind improve care is not straightforward. Assessing care quality is multi-faceted, the agenda and operating context is regularly evolving, and local behaviours can vary. To that extent, it is possible to point to examples of inquiry recommendations being implemented, but assessing whether those measures have truly delivered on their intention is necessarily more uncertain.

Evolving national priorities can lead to recommendations not being implemented

40. It is also the case that some recommendations from inquiries related to patient safety have not been taken forward because the government has made a decision not to, or because other priorities may have come to take precedence. One example is the Francis Inquiry's recommendation that NICE develop national evidence-based tools to establish the numbers of staff and skill mix needed to ensure services are able to deliver consistently safe care, with local compliance with those standards subsequently to be monitored by CQC. Work to develop these tools was initially progressed by NICE, but subsequently there was a decision to move away from that recommendation and take a more flexible approach to staffing ratios in the NHS.

Some changes are not amenable to national administrative or legislative solutions

41. Following the recognition of extensive care failings at Mid Staffordshire NHS Foundation Trust, the coalition government commissioned Don Berwick, a US-based patient safety expert, to lead a national review and report on how to drive care quality forward within the NHS. The crux of the resulting report, *A promise to act – a commitment to learn* (published in 2013), was a call for the NHS in England to become a learning health system whereby the ongoing process of improvement – including reducing harms and improving patient safety – was embedded in health care staff's day to day work (Exhibit JD/22 INQ0101397). This approach, which emphasises support for local improvement skills and capabilities, is likely the best way forward, but it is not amenable to national administrative solutions. Rather it focuses on inculcating a cultural shift in the NHS and that work takes time, it entails mobilising resources to provide staff and organisations

with skills and supporting tools, is subject to local variations and requires ongoing focus from national policymakers and elected leaders.

Lack of focus on enabling capabilities for delivering improvement

42. Embedding an effective approach to quality improvement throughout the NHS in England would be a large undertaking. Delivering that will rely on a programme management infrastructure – including a number of aspects: aligned national leadership for quality and improvement; a coherent set of strategic priorities; regional support and constructive scrutiny and challenge for provider organisations; dedicated management capacity or time to deliver locally within providers and systems; a focus on skills and knowledge development among local operational teams, managers and senior leaders; and a consistent set of metrics to monitor progress and opportunities to share learning among teams/professionals. Looking back over recent years, some elements of an effective transformation programme for improving care quality have been in place in England sporadically or in shifting form. They have not, however, been consistently in place and with the necessary durability to engender long-term change.

Some services appear to be at elevated risk and may require tailored responses

43. Looking back over the record of patient safety inquiries in the last decade, it seems clear that some services are disproportionately likely to be settings where unacceptable behaviours and failings in care can occur. In particular, maternity and neonatal services, and inpatient mental health care have been found – in some parts of the country – to be repeatedly falling short of the expected standards. Given these services have been the subject of recurring investigations, it suggests past recommendations have struggled to generate momentum for real change. As such, there may be a case for a particular focus on these high-risk settings and a distinct quality and safety improvement agenda tailored to the particular needs and challenges of these services (within the context of a broader coherent improvement approach for the NHS as a whole).

Translating intentions into real change depends on high-quality management and leadership

44. There have been numerous inquiries into failings of NHS care over the last several decades. Looking back at those inquiries highlights that recommendations are often well intentioned and tap into a prevailing and genuine desire at the time to bring about meaningful change, but then fail to generate enough momentum to remain a priority over

the longer term as events and policy priorities evolve and hence struggle to catalyse real improvements in local services. Overcoming this cycle of good intentions running into the sand will require a focus on how change is delivered in health care services. High-quality management and leadership of local services – supported by a coherent national infrastructure focused on safety and quality – will be essential. Yet in recent years, the centrality of good management to high-quality health care has been somewhat overlooked (Exhibit JD/23 INQ0101398. If the NHS is to make real progress on safety and care quality, a dedicated programme to boost management and leadership effectiveness within the NHS could play an important part. Any programme to deliver that could usefully focus on: i) addressing existing variations in management practice and quality; ii) improving training and development opportunities; iii) ensuring training is relevant to the operating conditions of contemporary health care; iv) addressing the 'thicket' of low-value activity that currently consumes much of managers' limited capacity; and v) driving a shift in perceptions of the importance and value of high-quality management in health care.

Statement of Truth

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

Signed: Personal Data

Dated: 17 April 2024_____