Witness Name: Sir Stephen Moss
Statement No:
Exhibits:
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THIRLWALL INQUIRY

WITNESS STATEMENT OF SIR STEPHEN MOSS

I, Sir Stephen Moss, will say as follows:

1. My entire career has been spent in the NHS. After qualifying as a registered nurse, I worked for a number of years in clinical practice in acute hospitals, before moving into a wide range of managerial posts, including over 30 years at board level.
2. The bulk of my career, i.e. from 1984 to 2005, was spent at Queens Medical Centre in Nottingham, (a large 1400 bed teaching hospital) where I was Director of Nursing, and latterly Chief Executive. During this time, in 1997 a new plan for the health system, *The new NHS. modern, dependable*, was introduced. This for the first time established a model of clinical governance, and a new national commission was set up (Commission for Health Improvement) to review how it was being embedded across the NHS.
3. I was appointed by the Secretary of State for Health, as one of the 13 commissioners. In this role, I supported the development and implementation of a plan to systematically review clinical governance in England and Wales.
4. Because of my interest in, and experience of, clinical governance, in 2009 I was asked to take on the role of Chairman at Mid Staffordshire NHS Foundation Trust, following the first highly critical report from the Healthcare Commission, the successor body to the Commission for Health Improvement. Together with a new Chief Executive, a new Board was established with a core focus on improving the quality of care and patient safety, to restore the trust of the local community in the hospital and the wider NHS.
5. It was during this time that I became more aware of the work of the airline industry and other safety critical organisations, in recognising the role of human factors in safety improvement, and the need to explore how this science might be applied in health settings. As a result, the Medical Director of the NHS asked me to Chair a Reference Group, including representatives with experience from the oil and airline industries and NHS educationalists, researchers, and leaders. We produced our Interim Report in March 2012 which recommended how Human Factors might be embedded in clinical practice, education, and research in health services. Responsibility for pursuing this action was passed to the National Quality Board.

6. I will expand on this later, but I am in no doubt that the NHS is slow at utilising the experience of other safety critical industries. Up to now, the drive to improve this situation has come mainly from individuals and charitable organisations. This for me is a cause for concern.
7. Throughout my career I have been driven by a set of strong public service values and an approach that our role as leaders is to provide those colleagues at the front line of care with the support they need to keep patients well cared for and safe.
8. Pursuing my interest in this area further, on the 15 August 2018 I became a Trustee of Patient Safety Learning, a registered charity in the UK. Established in 2018, they seek to harness the knowledge, enthusiasm and commitment of healthcare organisations, professionals and patients for system-wide change and the reduction of harm.
9. Patient Safety Learning supports safety improvement through policy, influencing and campaigning and the development of 'how to' resources such as *the hub*, an award-winning platform to share learning for patient safety. This is a free to use site, which offers a combination of tools, resources, stories, ideas, case studies and good practice to anyone who wants to make care safer for patients in the UK and globally.
10. The platform also hosts and supports a growing number of informal communities of interest that give people a place to discuss patient safety concerns and how to address them. The foremost of these is the Patient Safety Management Network, open to patient safety managers and everyone working in patient safety. It holds weekly drop-in sessions for members to come together and discuss ideas and activities from both within and outside of healthcare that can help improve patient safety. In just under three years this has grown to have over 1,600 members from more than 600 organisations in the UK.
11. They have also developed a unique set of Patient Safety Standards and support tools. The starting point for these Standards is their 2019 report, *A Blueprint for Action*. This report draws on twenty years of research into patient safety and avoidable harm, analysing why patient safety is a major and persistent problem and sets out the systemic causes of unsafe care. The individual standards themselves are cross referenced against the findings and recommendations from inquiries, policy and good practice from healthcare, such as the *Berwick review into patient safety* and the *Kark review of the fit and proper persons test*.
12. Most recently, Patient Safety Learning has been working with Great Ormond Street Hospital and other NHS trusts to use the 'What Good Looks Like' standards framework to assess their performance and develop organisation wide patient safety improvement strategies.

13. I stood down from my role as a Trustee of this charity on 22 February 2024, following the appointment of a number of excellent additional trustees who can bring a very sharp focus on the impact of current patient safety policy on patients and frontline staff.

14. It can be seen from my background, that throughout my long NHS career, I have maintained a strong focus on patient safety and quality of care, and in particular the vital role of boards in supporting front line teams deliver this. In response to this Rule 9 request in relation to the Thirlwall Inquiry into events at the Countess of Chester Hospital and their implications, I should like to expand my thoughts in three key areas i) Patient safety and leadership; ii) Culture and raising concerns; iii) Patient safety governance.

i) Patient safety and leadership

15. Leadership plays a key role in creating and maintaining patient safety. While good leadership that models high standards and behaviours can be a powerful force in shaping a positive safety culture, poor leadership has the opposite effect. This applies not just to individual organisations themselves, but also the healthcare system more broadly.

16. Failures in patient safety leadership are a recurring theme we see emerge from reviews and inquiries into serious healthcare scandals. Two recent examples of this have been the reports setting out the findings of the independent review of maternity services at Shrewsbury and Telford Hospital NHS Trust and the investigation into maternity and neonatal services at East Kent Hospitals NHS Foundation Trust.

17. The report *Final findings, conclusions and essential actions from the Ockenden review of maternity services at Shrewsbury and Telford NHS Trust* draws together evidence from 1,486 families, some with multiple incidents, in maternal and neonatal care. The review found "repeated failures in the quality of care and governance at the Trust throughout the last two decades".

18. In particularly it highlighted serious failures in governance and leadership at the Trust as a key factor contributing to this. The report cites constant change at Board level resulting in the Trust's leadership failing to support a positive environment in the organisation, and notes that it did not have the necessary oversight, or a full understanding of the issues and concerns raised about maternity services at the Trust. It highlights how failings at this level "meant that consistently throughout the review period lessons were not learned, mistakes in care were repeated and the safety of mothers and babies was unnecessarily compromised as a result".

19. *Reading the signals: maternity and neonatal services in East Kent – the report of the independent investigation*, looked in detail at a series of serious patient safety failings

between 2009 and 2020. This investigation found that if nationally recognised standards had been followed, the outcome could have been different in 97 of the 202 cases reviewed.

20. This report highlighted failings related to those at a leadership level not identifying and preventing avoidable harm to patients and deaths at the Trust. It pointed to numerous concerns in this respect, including poor executive and non-executive relations, insufficiently robust governance structures and lack of external benchmarking of performance and serious incidents. It noted that "the Trust Board itself missed several opportunities to properly identify the scale and nature of the problems and to put them right".

21. It also stated that "too often the Trust has focused on reputation management, reducing liability through litigation and a "them and us" approach. Again, this has got in the way of patient safety and learning".

22. Questions about leadership for patient safety have more recently been explored by the Health and Social Care Select Committee's Independent Expert Panel. In their report, *Evaluation of the Government's progress on meeting patient safety recommendations*, they looked at the implementation of recommendations concerning both maternity safety and leadership as well as the training of staff in health and social care more broadly.

23. In looking at a recommendation from Sir Gordon Mesenger's report, *Leadership for a collaborative and inclusive future*, they noted that in contacting the Department of Health and Social Care on this issue, they saw "no evidence about the impact of existing patient safety training". From a roundtable undertaken as part of their evidence gathering process, they advised that they had been told about variability in leadership on boards, particularly among non-executive directors, with some of those they spoke to arguing that they may not have the skills to challenge reports on patient safety.

24. The findings of these inquiries and reports in relation to leadership underline a long-recognised issue, namely that good leadership is key to delivering safer care. This was also an area covered by Sir Robert Francis's *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*, which included a number of recommendations in this regard.

25. The charity Patient Safety Learning have also identified "Leadership for patient safety" as one of the six core foundations of safer healthcare in their 2019 report, *A Blueprint for Action*. In this they state that "we need a model for leadership and governance for patient safety in health and social care that sets and requires high and consistent standards and behaviours for our leaders".

26. In their Patient Safety Standards, Patient Safety Learning expand on this emphasising the value of organisations having a published patient safety strategy and goals for improvement, informed by an evidence-based assessment of patient safety risk with clear roles and responsibilities and governance for delivering improvement - proactively not just responding to incidents of unsafe care.
27. I would concur with this position and believe that patient safety should be seen as a core responsibility of Boards.

28. Currently there is a lot of rhetoric that goes on and many chairs and board members tell me that patient safety is obviously their priority. But when I follow that up by asking what this means in practice, the response is often disappointing. Boards and leaders need to better understand that their primary role is to provide staff on the frontline with everything they need to do their job well—and the most important part of that role is to keep patients safe.

29. NHS England recognises the importance of building leadership and safety improvement capability across the system in its National Patient Safety Improvement Programmes, a key part of *The NHS Patient Safety Strategy*. However, it does not currently measure this against a clear set of standards for patient safety leadership, aligned with culture change. It can therefore be difficult to for those within the system to be clear on 'what good looks like' and what action they need to take to achieve this.

30. In my personal board level experience, I have constantly adopted an approach of 'the buck stops with the board'. To emphasise this, I was shocked and disappointed when I undertook a series of workshops for board members, on the events at Mid Staffordshire NHS Foundation Trust, and listened to numerous Chairs telling me that their board saw patient safety as their top priority, yet couldn't tell me what their top three risks were. I should like to think that there has been an improvement since then but, I fear there may still be a long way to go before the rhetoric matches the reality.

31. In my view it is absolutely vital that the board, both executive and non-executive directors, 'live and breathe' the values of the organisation and are seen and acknowledged to do this by those staff on the front line. This role modelling by the board is a powerful tool for creating change and culture improvement.

ii) Culture and raising concerns

32. It is vital that NHS staff feel able to raise, report and discuss safety concerns and opportunities for improvement. This is not simply a principle that applies to healthcare but

is vital across all safety critical industries. When organisations have a culture that seeks to assign blame when things go wrong, harm is more likely to happen.

33. What is required to create a safe environment for staff to raise safety concerns is often referred to as a 'just culture'. Professor Sir Norman William's Review into *Gross Negligence Manslaughter in healthcare* states that in such a culture "inadvertent human error, freely admitted, is not normally subject to sanction to encourage reporting of safety issues. In a just culture, investigators principally attempt to understand why failings occurred and how the system led to sub-optimal behaviours. However, a just culture also holds people appropriately to account where there is evidence of gross negligence or deliberate acts".

34. In the 2015 report, *Freedom to speak up: An independent review into creating an open and honest reporting culture in the NHS*, Sir Robert Francis QC sets out a number of principles to support this. The first of which is that "every organisation involved in providing NHS healthcare, should actively foster a culture of safety and learning, in which all staff feel safe to raise concerns".

35. Patient Safety Learning in their 2019 report, *The Patient-Safe Future: A Blueprint for Action*, alongside "Leadership for patient safety" select this as another key foundation of safe care. They state that "in a patient-safe future, an organisation's culture encourages and supports patient safety". Evidence shows that improving safety culture impacts on staff safety behaviours, and that improvement initiatives, in turn, improve culture. In short, they form a virtuous circle.

36. The importance of this is also recognised in *The NHS Patient Safety Strategy*, published in 2019. The Strategy identifies "a patient safety culture" as one of the two core foundations of this strategy. The document sets out key features of a patient safety culture and actions to be taken in local systems and nationally to develop this.

37. Although there is a broad consensus on the importance of this and its role in creating and maintaining the conditions required for patient safety, this has proved to be more difficult to implement in practice. There is substantial evidence that in significant parts of the NHS there remains a culture that inhibits members of staff from raising concerns about patient safety.

38. One significant indicator of this is the results of the NHS Staff Survey. This is conducted on an annual basis and asks staff in England about their experiences of working for their respective NHS organisations.

39. Last year, reflecting on the results of the 2022 NHS Staff Survey, the National Guardian's Office highlighted significant concerns about what the results of this survey told us about staff views on speaking up on patient safety issues. In their report, *Fear and Futility: what does the staff survey tell us about speaking up in the NHS?*, they noted that "two in five workers in the NHS do not feel able to speak up about anything which gets in the way of them doing their job".

40. The results from the 2023 survey, published earlier this year, have shown little change from previous years survey, with a similar percentage of respondents unable to say they felt safe to speak up about anything that concerns them in their organsiation. In its *National Results Briefing 2023*, NHS England noted that this year's scores meant that "when it comes to concerns about clinical safety, the percentage of staff who feel secure raising such concerns is now at a five-year low".

41. The 2023 survey results also highlighted that: i) nearly half of respondents (49.93%) could not say they were confident that their organisation would address their concern they raised; ii) 40.55% of staff could not say that their organisation treated staff who are involved in an error, near miss or incident fairly; iii) more than 30% of staff could not say that when errors, near misses or incidents are reported that their organisation takes action to ensure these do not happen again.

42. These findings are reinforced by fears about speaking up and unfair treatment appearing as a recurring theme in major patient safety scandals and subsequent inquiries, including the reviews at Shrewsbury and Telford and East Kent referenced in the previous section of this statement.

43. We also see this consistently reinforced by the experiences and testimonies of whistleblowers. Increasingly we see high profile news coverage concerning cases where healthcare professionals raising patient safety concerns are met with a hostile and aggressive response, rather than one open to challenge and scrutiny.

44. In a new report this year, *We are not getting safer: Patient safety and the NHS staff survey results*, Patient Safety Learning highlighted a number of these issues in the context of the 2023 NHS Staff Survey results. They stated that "the staff survey results indicate that blame cultures and a fear of speaking up continue to persist in a significant part of the NHS".

45. This report calls for greater clarity from NHS England on implementing culture change, beyond publishing new guidance and information for Trusts on the theory of this. It specifically cites the need for more examples of implementation in practice and for an

expansion of activity to evaluate the impact of culture change programmes where these have been implemented.

46. Concerns around safety culture have also been highlighted by the Health and Social Care Select Committee's Independent Expert Panel in a recent review assessing the progress the Government has made in implementing accepted recommendations made by inquiries and reviews into patient safety.

47. In their report also referenced in the previous section, *Evaluation of the Government's progress on meeting patient safety recommendations*, they looked at progress made in implementing the previously mentioned principle in the Francis Review that healthcare organisations should actively foster a culture of safety and learning. It suggested that Government efforts to implement this "requires improvement".

48. It is my personal view that there are at least two issues limiting progress.

49. Firstly, the vital role of the board in creating a culture which is seen to be welcoming and supportive of those that speak out, and explicitly seeks to learn, rather than punish (a just culture, as defined by Professor Williams review mentioned earlier in this section). This culture needs to be accompanied by the organisation being committed not only to listen to staff, but act on their insights – by making improvements, evaluating their impact to drive the reduction of avoidable harm

50. Secondly, I feel strongly that it is a core responsibility of all healthcare professionals to speak out when they see poor practice or behaviours. In my experience, unchecked poor practice or behaviours expose patients to unnecessary risk and will soon become normalised as the way things are done. This is clearly written into codes of professional conduct, but in my view needs more reinforcement as part of education systems preparing students to make the change into qualified practitioners. In other words, it goes with the territory of being and professional and is not an optional extra.

51. In my experience I found that front line staff appreciate a menu of options for speaking out, and value a range of approaches where they can choose the option that they feel most comfortable with. A particularly useful approach that I have found effective in the past is where in my role as the non-executive chair of the Quality Assurance Committee in a trust, I worked with the Freedom to Speak Up Guardian to undertake regular 'surgeries' where staff could raise concerns.

52. Further to this, in my view professional regulators should agree a common set of behavioural standards across all healthcare professions, reflecting the increasing trend for care to be developed by teams of different healthcare professionals.

iii) Improving patient safety governance

53. In my view the primary responsibility for establishing sound governance and assurance systems rests with the board, and again it relies heavily on a culture where assurance is seen as important and deals with the answer to the simple question: 'How do we know we are as good as we think we are?'. Too often I have seen board papers that focus on commentary, rather than measuring impact and outcomes, and this, in my view often stems from a poor understanding of their assurance role on the part of executive directors.

54. There is no doubt in my mind, that to support this culture of assurance, governance systems should be uncomplicated and bedded in from ward to board. Systems should balance process with outcome, and data/intelligence should be triangulated for authenticity.

55. Above all, systems should 'get under the skin' of what is going on and tell the board a story rather than just present numerous graphs, bar charts and numbers. Importantly boards should seek ways to 'humanise' assurance reports so that it is clear what the human impact is of the service effectiveness.

56. Of course, the protection of the public and users of the service is vital, and therefore there is an important role for external, independent scrutiny, especially in the core area of patient safety. In my experience (albeit some time ago) there is a need for this scrutiny to be more focused and coordinated between regulators.

57. Another issue to consider when looking at Boards and improving patient safety governance is the different component parts of these bodies.

58. Non-executive directors for example have a specific accountability role set out by NHS England, including a) ensuring that the board sets challenging objectives for improving its performance across the range of its functions; b) holding the executive to account for the delivery of strategy; c) providing purposeful, constructive scrutiny and challenge.

59. However, it is not clear that we currently give significant consideration to their skills and experiences of patient safety. For example, what training they have had, whether they feel able to effectively hold the management to account on these issues, and how their considerations interact with other organisational and external pressures, such as regulatory regimes.

60. Another consideration is executive roles that report into the Chief Executive and have visibility with the board. Typically, there is no Chief Safety Officer with a Board level responsibility in healthcare organisations, in contrast to other safety critical industries. Safety tends to be pushed down the 'chain of command', meaning at executive level the

leader interacting with the Board does not always have a specialist understanding and awareness of patient safety issues.

61. The NHS has introduced in recent years the new role of Patient Safety Specialists, who are individuals in healthcare organisations who have been designated to provide dynamic senior patient safety leadership. All NHS organisations are required to identify one or more Patient Safety Specialist, with this now a provision in the NHS contract.
62. In its *Requirements for Patient Safety Specialists*, NHS England sets out that these individuals should: a) have immediate and direct access to an executive lead for patient safety who they regularly meet with; b) work with the executive lead for patient safety in reviewing the NHS patient safety strategy, how it relates to local patient safety priorities and agree an appropriate approach to implementation/delivery; c) attend board meetings as required to be involved in discussions relating to patient safety.
63. It is still too early to assess whether the introduction of Patient Safety Specialists may have a significant impact the quality of information type of assurance received from Boards on patient safety issues. However an early analysis of these new roles, recently published by the THIS Institute (a research institute, led by the University of Cambridge, focused on improving the science behind healthcare organisation and delivery), has pointed to challenges concerning how these roles are resourced and how supported the individuals in these roles feel by their organisations.
64. Turning back to requirements for patent safety leaders, the charity that I was formerly a trustee of, Patient Safety Learning, is implementing patient safety standards in this area.
65. Patient Safety Learning argues that one of the primary reasons for the persistence of avoidable harm is that healthcare does not have or apply standards of good practice for patient safety in the way that it does for other issues.
66. As mentioned earlier in this statement they have developed a unique set of Patient Safety Standards and support tools. These are intended to inform 'what good looks like' and enable organisations to self-assess against them, helping them prioritise their patient safety improvement activities. The Standards themselves are based on 20 years of research, as well as learning from inquiries, policy, and good practice from healthcare, both in the UK and internationally.
67. Their Standards identify “Leadership and governance” as one of the seven foundations of patient safety.
68. To meet their Standards in this area an organsiation needs to: a) demonstrate patient safety is a core purpose of the organsiation; b) show that patient safety is embedded in governance and risk management; c) have an organisation patient safety plan with

accompanying objectives and resources to ensure implementation; d) ensure safety is built into the planning and delivery of new services; e) model and promulgate safety behaviours from the top down and bottom up.

69. Under their "Leadership and governance" category there are six aims for organisations to self-assess against, composed of 35 separate standards with details of outputs, evidence, outcomes, and behaviours that would be expected if the standards are to be met

70. Finally considering safety governance in healthcare from a broader perspective, there is no doubt in my mind that the NHS is slow to learn from other safety critical industries. In areas such as aviation and nuclear power, a safety management system (SMS) approach is used to help enable proactive assessments of risks, specification of how risks should be managed, and set clear lines of accountability and responsibility in addressing risks.

71. A recent report by the Health Services Safety Investigations Body has begun to explore how an SMS may operate in healthcare to help better equip the system to identify, respond, and proactively identify emerging and recurring concerns that may impact on the safety of patients. In my view would be valuable for the NHS as a system to develop such an approach, which could potentially provide a wider safety framework under which other new initiatives, such as patient safety standards, could sit.

72. It is my hope that this submission will help to support the public inquiry in its work in investigating the events at the Countess of Chester Hospital and the wider issues of NHS governance, patient safety and culture related to this.

Statement of Truth

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

Signed: PD

Dated: 17 June 2024