Witness Name: Professor David Oliver
Statement No.: 1
Exhibits:
Dated: [XXXX]

THIRLWALL INQUIRY

WITNESS STATEMENT OF PROFESSOR DAVID OLIVER

I, Professor David Oliver, will say as follows: -

1. **Into the events at the Countess of Chester Hospital and their implications following the trial and subsequent convictions, of former Neonatal Nurse, Lucy Letby of murder and attempted murder of babies at the hospital**

2. Part C of the Inquiry

3. "The effectiveness of NHS management and governance structures and processes, external scrutiny and professional regulation in keeping babies in hospital safe and well looked after, whether changes are necessary and, if so, what they should be, including how accountability of senior managers should be strengthened. This section will include a consideration of NHS culture"…….

The structure of my written evidence to this Inquiry:

4. I was approached to give evidence to this inquiry, initially because of articles I had written in the *British Medical Journal* and *Health Service Journal* around the relationship between managers and clinical staff in the wake of the verdict, on the reality that many managers are registered clinicians by background and some of the issues that might not make statutory registration and regulation of managers a panacea to cases like this.

5. Also because of my broad experience in a range of medical leadership and policy roles, although I am not a Paediatrician or Neonatologist.

6. The Legal team at Field Fisher put a range of questions to me that I might want to address in my evidence and which were in line with the themes to be covered in Section C. They also encouraged me to mention any other issues that I thought might be of relevance.

7. I have set my written evidence out under 10 headings and have provide a brief summary of my responses under each, set out on the following page. I have listed 209 references supporting my evidence. Direct quotes are in italics and key reference documents picked out in bold font.

8. Summary of my written evidence under each of 10 headings.

9. I have structured my written evidence under the following 10 headings.

My career, qualifications, experience and areas of professional interest

Underlying structural and cultural Issues affecting NHS performance, workforce morale and retention and so indirectly affecting patient safety and care quality.

The importance of culture, governance, and management structures in the NHS to ensure the quality and safety of care and better working relationships between managers and clinical staff including doctors p

The selection, quality, training and oversight of NHS managers

The calls for statutory registration and regulation of NHS managers. How useful and feasible a protection would this be?

The implications of Clinical Professionals working as Managers

The implications and impact of the professional duty of candour and transparency for regulated clinical professionals and statutory duty of candour for NHS Organisations

The impact of "Freedom to Speak Up" guardians and protections

The culture, legislation, regulations and systems around patient safety, avoidable incidents harms or deaths

Specific sources of information, data, guidance and standards relating to neonatology and neonatal intensive care units

10. I have set out brief summaries of my evidence under each of the headings below

My career, qualifications, experience and areas of professional interest

11. I am not a Paediatrician or Neonatologist or expert in these fields. However, alongside a long NHS career as a practising hospital doctor including 26 years as a Consultant, I have played a wide variety of national leadership and policy roles and been a long standing policy commentator and medical writer and researcher. This has included work relevant to patient safety, audit and mortality.

Underlying structural and cultural Issues affecting NHS performance, workforce morale and retention and so indirectly affecting patient safety and care quality.

12. The NHS is currently struggling with its worst performance on access, wait times, response times, waiting lists, staff satisfaction, staff retention, patient and public satisfaction for many years. Facilities and equipment are also in a poor state and have been underinvested in. The Covid-19 pandemic has amplified and accelerated some of this and there are now ongoing industrial relations disputes.

13. Staff are increasingly facing burnout and moral distress and there are ongoing concerns over the quality and safety of services and risks to patients. This is therefore not a conducive environment for an open and just culture, for learning from mistakes or preventing harm. Indeed, it may provide the conditions that make such problems more likely.

The importance of culture, governance, and management structures in the NHS to ensure the quality and safety of care and better working relationships between managers and clinical staff including doctors.

14. There have been any number of inquiries, investigations, reports and recommendations into care failings and culture in the NHS. There remain often excellent management teams and organisational or departmental cultures and often close working between doctors, other clinical staff teams and managers.

15. However, we have a very centralised, top-down structure in the NHS which has persisted through any number of reorganisations and which often priorities financial "grip", regulatory standards and delivery of key performance indicators and targets and cascades down through regional offices and regulatory bodies. This in turn puts considerable pressure on executives and managers at local level and also makes it hard for them to speak out.

16. And although some of the key targets and indicators and regulatory requirements are very much concerned with improving the safety and quality of care, sometimes they bring the values and priorities of managers into conflict with those of clinical professions, make it hard for managers to speak out and challenge national policy or take more control of local decision making and culture and often in turn make "Bad news" flagged by "challenging" clinicians unwelcome. Though sometimes clinicians themselves can resist service innovation and improvement initiatives, causing further frustration to managers.

The selection, quality, training and oversight of NHS managers

17. Managers are selected for the NHS from a diverse variety of entry points. Some have clinical qualifications and backgrounds and have worked up through the management ladder either in clinically-designated roles or management roles also open to non-clinicians. Some come from the NHS graduate management training scheme.

18. Others from Finance, Law, Human Resources or from specialist areas like Estates Facilities and Information Technology. Others are recruited from other parts of the public sector, Government agencies, or from the private sector. Whilst managers are essential to good health services and their numbers have been cut in recent

years and their role sometimes undervalued and disparaged, I would welcome some more standardisation in terms of training and competencies and knowledge they should have to demonstrate and be assessed and regularly appraised on.

19. However, in my opinion, the biggest issue that NHS managers face is that the NHS structure is so top down, so "command and control" in its model that they are under tremendous pressure to implement Government imperatives, including key targets and financial controls and regulatory standards and their survival in post often depends on this.

20. This hierarchical structure also makes it hard for them to challenge and speak out openly on issues around safety and quality of care or to react sufficiently to problems raised by frontline staff about resource, workload, environment or safety. And the way they are judged and performance managed makes such a transparent, outspoken, honest and challenging approach difficult for them to adopt and yet remaining in post.

21. Managers' role is also severely constrained by resources and workforce gaps and those numerous, often clashing, central imperatives. The 2021 report on NHS management and leadership by General Sir Gordon Messenger made a series of recommendations and was commissioned and endorsed by the Department of Health and Social Care and NHS England. Implementing the recommendations might be a useful starting point rather than commissioning yet more reviews.

The calls for statutory registration and regulation of NHS managers. How useful and feasible a protection would this be?

22. I am not against the statutory registration and regulation of NHS managers. There is also moderate support from managers themselves when they are surveyed. However, it is not a panacea for some of the problems identified in the Letby Case.

23. Firstly, because already a large number of NHS managers have clinical registration with a clinical regulator or have other professional regulators for instance for finance professionals. Yet this fact has rarely led to any censure or restrictions on practice for managers and executives who are already registered relating to bullying, silencing whistle blowers, suppressing or hiding bad news or failing to create and open, listening

and just culture. So why would this be any different if managers had their own regulatory body?

24. Secondly, because (rightly so in my view) the bar for level of incompetence or unprofessional behaviour or deceit required to disbar someone from future practice or place serious restrictions on their practice should be set high and failings in organisations often result from wider structural problems outside those managers' direct gift. I see no evidence in this or other high profile cases recently that the senior managers in post at the time would have been disbarred from some professional register before the events had occurred, due to previous poor behaviours.

25. Thirdly, because there is already considerable regulation, performance management and scrutiny for managers or directors. For instance from the CQC Regulation 20 on the statutory duty of candour, from CQC inspections, from the Governance framework for NHS Trusts and the NHS operating plan and key indicators, from annual appraisal by their own line managers and from the "fit and proper persons test". Yet these have not been a bulwark against care failings and patient safety scandals.

26. Fourthly, because statutory regulation and registration tends to be for professions with a clear and consistent set of qualifications and entry requirements and routes into NHS management are not standardised or mandatory. There would have to be consensus about who counted as a "manager" for these purposes.

27. Fifth because any regulator would have to be completely independent from NHS England which has a clear conflict of interest in having to deliver and performance manage central targets and objectives. I can certainly see the utility of regulation in preventing some rogue individuals who made egregious mistakes from going on to further senior jobs within the NHS but that will never be more than a handful of managers, most of whom do their best in difficult circumstances. My main plea is that any regulation has to make the creation of an open, transparent and just culture paramount, first among equals in the standards, so that staff or patients or families raising concerns are listened to, enabled to do so safely with no impact on their own careers and their concerns taken seriously.

28. Any attempt to silence or bully or constructively dismiss or force non-disclosure people raising concerns or whistleblowing or to cover up systemic care failings especially when there are risks to patient or staff welfare and safety should result in very serious

action against those individuals. At the moment, in my view their performance is judged more harshly for failing to hit Government targets or controls and there is a culture of not admitting to bad news, openly unsafe levels of resource or staffing or risks to patient care or of senior managers acknowledging these issues or challenging Government or central agencies.

The implications of Clinical Professionals working as Managers

29. There is evidence from academic research on organisational leadership and management that technical professional experts who are trained and experienced in the "core business" of the organisation (in the case of the NHS, patient-facing clinical care) tend to make better line managers. They have credibility and understand the work and have done it themselves.

30. There is also a good rationale for clinically-led organisations. Much of the spend is on employment of clinical staff and most of the key decisions on treatment, investigation, admission, discharge and review sit with clinicians and this in turn influences both organisational performance, spend and patient safety. So why not give more of that responsibility and accountability to clinicians? There have been some positive experiences around the world with this approach and in some other countries it is quite normal for Board level Executives to be clinicians.

31. Around one in three managers or people with management roles are clinicians – some of them (mostly doctors) continuing with their patient-facing clinical practice. Some of them are in jobs that do not explicitly require clinical qualifications but are open to others. Some management roles right up to Board level are explicitly clinical ones. However, it is important to select clinicians with the right aptitude for management and to ensure they are equipped with the right technical knowledge management and leadership skills and have appropriate training and support.

32. The mere fact of being a good or credible clinician is no guarantee of being a good or credible manager, even if it might be a "head start" in terms of managing clinical staff. Although regulatory codes of practice and professional duties are very clear that doctors, nurses and allied health professionals in management role have clear responsibilities about creating and enabling an open, just, listening culture which values and encourages staff concerns and puts patient safety and staff wellbeing front and centre, in reality, this has not resulted in much regulatory action. And the fact that

some managers have clinical backgrounds has proved no bulwark against behaviours such as silencing or ignoring staff members who raise concerns, burying bad news or failing to be open and transparent about care failings.

33. In my view, there is a clear danger that once clinicians take on management roles (especially if they then give up all of their direct patient care clinical practice) they will prioritise corporate imperatives, hitting Government performance indicators and "managing upwards" rather than outspoken patient advocacy or solidarity with frontline clinical staff. While I completely support the growth of clinician-managers it is no panacea and would not necessarily prevent a case like Letby's. During 2016 and 2017 the CEO, Director of Nursing, Medical Director and Divisional Director involved were all registered, qualified clinicians by background.

The implications and impact of the professional duty of candour and transparency for regulated clinical professionals and statutory duty of candour for NHS Organisations

34. There exists both a professional duty of candour, set out by the General Medical Council, Nursing and Midwifery Council and other professional regulators which tells registered professionals that they "must" (not "should") raise concerns about risk to patient safety, about errors or harms to patients. It also places an obligation on registered clinicians in management roles to create a safe environment for concerns to be raised and to listen to, investigate and act on concerns.

35. There is a parallel statutory duty of candour for NHS provider organisations (set out in Regulation 20 of the CQC regulations) to be open and transparent about risks, harms and incidents. There is also a national patient safety strategy and national safety incident reporting framework. And a series of recommendations made in Baroness Cumberlege's 2020 review "Patients First and Foremost" about Safety and in the 2013 Berwick Review.

36. There is also a national patient safety commissioner – currently Dr Henrietta Hughes. Dr Hughes herself recently described the statutory duty of candour as a "tick box exercise" which managers were too busy to implement properly. A failure to adhere to the professional duty of candour does not seem to have been used much by regulators in disciplinary or fitness to practice proceedings.

37. Nor does the statutory duty of candour for organisations seem to be have been enforced much by the CQC or changed organisational behaviour and culture. Indeed the immediate past Chief Inspector of hospitals told the Cumberlege inquiry that as yet there still a closed culture which suppressed or played down bad news or concerns. Both organisational leaders and professionals need to be supported to be genuinely candid and open

The impact of "Freedom to Speak Up" guardians and protections

38. I welcome the creation of a National Freedom to Speak up Guardians' Office and an army of local Freedom to speak up guardians throughout the NHS and the notional protection that freedom to speak up policies give to staff who raise concerns about risks, errors and harms.

39. And it is encouraging to see the range of case studies set out by the Guardian's Office where the Freedom to Speak Up protection and office has enabled concerns to be raised. However, academic evaluation of the impact of this policy has proved inconclusive and there are numerous examples from before, during and after the Covid-19 pandemic, including reports into care failings in individual Trusts, or failings in support and protection of NHS staff that show we still have a long way to go before staff feel confident in using freedom to speak up as a matter of course or confident that their concerns will be taken seriously and not damage their own jobs.

40. At the moment, the policy risks looking more like noble intent than concrete and effective action. And there is still fear that being open, outspoken and challenging about problems will harm the careers of individuals or the reputation of organisations and make their lives more difficult. We need a different environment and culture to make the ambition a reality.

The culture, legislation, regulations and systems around patient safety, avoidable incidents harms or deaths

41. There is already a considerable body of evidence, guidelines, recommendations, national agencies, inquiry findings, reporting mechanisms, practice frameworks and audit programmes to measure, learn from and improve quality of care including patient safety and to learn from avoidable harms, serious incidents and deaths.

42. We have the recommendations of the 2013 Francis Inquiry and Government Response, the 2013 Berwick Report, the 2020 Cumberlege Review, the work of the Health Service Safety Investigation Bureau and its approach to safety investigations and recommendations, a National Safety Strategy, NHS England Safety Directorate and Safety Commissioner and several national good practice guidelines and frameworks.

43. There are national clinical audit and quality programmes funded and overseen by the Health Quality Improvement Partnership (HQIP). There is a national "learning from deaths" programme and a national medical examiner of deaths as well as an army of local medical examiners of deaths to scrutinise, discuss and advice on death certification and a national coroners' office and national guidance and legislation on referral to coroners. Not all of this apparatus was in place during 2016-17 when the murders and attempted murders Lucy Letby was convicted of took place. But it is very much in place now and could provide a useful protection and earlier learning around clusters of unexpected and unexplained deaths.

44. Although it would have to be utilised properly, I do not believe the deaths in the Letby Case were referred to the Coroner at the time and even without all the current initiatives and programmes we now have in place that might have offered opportunities to learn and intervene, albeit this was an extreme case.

Specific sources of information, data, guidance and standards relating to neonatology and neonatal intensive care units

45. I am not qualified or trained in Paediatrics, neonatology, Paediatric or Neonatal Intensive Care and have no bespoke expertise in those fields. However, I can see that there are in place two relevant national clinical audit programmes. The National Neonatal Audit Programme (NNAP) and the MMBRACE (Mothers and Babies, Reducing Risk through Audits and Confidential Inquiries) Programme.

46. There are service specification and staffing guidelines from the Royal College of Nursing and from the British Association of Perinatal Medicine. There are National Quality Board Guidelines on reporting and learning from deaths which also apply to children, infants and neonates. And legislation on indications for referring to coroners as well as expert professional guidance on referral. And guidance suggesting the use of safeguarding protocols for structured learning from deaths.

47. There are regular national data reports on activity, capacity and staffing in Neonatal Units. The CQC inspects services for children and young people on its visits. NICE published good practice guidance on neonatal care and neonatal intensive care. NHS England has a "Maternity and Neonatal Programme" which is clinically led and reports regularly and the Royal College of Paediatrics and Child Health has a key role in setting standards. In short, there is no shortage of guidance, data collection, data reporting and national oversight which can be deployed to ensure and assure the safest possible care for neonates.

48. The question is to what extent it is consistently deployed and what factors prevent implementation or prevent problems coming to light and being acted upon in 2024 and beyond rather than the context in 2016-2018 in which Lucy Letby's crimes were committed and clinicians at the Countess of Chester were raising concerns about anomalous deaths and her potential role. This concerns takes us back to the issues raised in early sections about NHS resource and staffing constraints, culture, competing priorities and candour or lack of it.

My career, qualifications, experience and areas of professional interest

49. I am Professor David Oliver, a Consultant Physician specialising in Geriatric and General Internal Medicine and with a Certificate of Completed Specialist Training (CCST) in both.

50. I am not a Paediatrician or Neonatologist and have no training or experience or expertise in those fields, although many of the issues raised by the Letby Case and of interest to this inquiry are generic ones that transcend particular clinical disciplines.

    a. I was asked to give evidence to the Inquiry partly as a result of an article I had written in my regular **British Medical Journal (BMJ) Column**. *"A Clinicians versus Managers Blame Game is a False Dichotomy"* published in August 2023.

    b. I have been an NHS doctor since 1990, initially in rotational junior doctor posts and then a Consultant Physician since 1998 – initially at Queen Mary's Hospital, Bexley and, since 2004, at the Royal Berkshire NHS Foundation Trust, where I was also a senior lecturer at the University of Reading until 2009. Since 2009, I have been a visiting Professor at City University of London.

c. My General Medical Council (GMC) registration number is I&S

51. My qualifications are:

a. BA Physiological Sciences, Oxford University, 1987
b. MB, B Chir., Cambridge University, 1989
c. MRCP (Member of the Royal College of Physicians) (UK) 1993
d. Diploma Geriatric Medicine 1993 (RCP London)
e. Diploma Advanced Study in Health Service Management, Imperial College Business School 1998
f. MD (Research Doctorate), University College, London 2001
g. Diploma Medical Education King's College London 2002
h. FRCP (Fellow of the Royal College of Physicians) London 2002
i. MSc Health and Social Care Leadership, Middlesex University and NHS London 2004
j. MA Healthcare Law and Ethics, Manchester University, 2007

52. In addition to my job as a still very active clinical practitioner in the NHS, I have played a variety of other appointed or elected national professional leadership and policy roles in Medicine including:

a. Secretary, then President of the British Geriatrics Society
b. Clinical Vice President of the Royal College of Physicians of London (RCP) (with overall responsibility for the RCP's work on audit, accreditation, quality, safety, mortality and the "chief registrar" programme and a senior officer and trustee of the college.
c. National Clinical Director for Older Peoples Services in the Department of Health, including co-leadership of national clinical improvement programmes around falls and fractures.
d. Specialist Advisor the NHS Improvement Emergency Care and Intensive Support Team
e. Visiting Fellow, King's Fund Health Policy Think Tank
f. Trustee, Nuffield Trust Health Policy Think Tank
g. Trustee, Royal Society of Medicine

53. I am also a well published academic researcher, with numerous papers, review articles, editorials, abstracts and book chapters, especially in the field of the organisation and delivery of health and care services for older pe1ople, prevention and care for older people with falls and fractures, safety and quality in care for older people and ethical issues for instance around age discrimination and the balance between risk, protective measures, safety and autonomy. I have been lead or co-author on numerous

54. I was a senior lecturer in the School of Health Sciences at the University of Reading.

55. I am now a visiting Professor at the School of Community and Health Sciences, City University of London.

56. I have been a weekly *BMJ* columnist for many years, with over 400 columns also writing for various national newspapers, news sites, healthcare trade press. I am a member of the Medical Journalists Association and have been shortlisted for the Professional Press Association (PPA) professional columnist of the year award.

57. My writing has included some investigative stories based on freedom of information reports to government agencies around Covid-19 protective equipment and around NHS use of management consultancy.

58. My more general writing in opinion columns, explainers, policy commentary has covered a wide range of issues around health policy, care for older people, health systems, ethical and legal issues, professional working lives, responses to the Covid-19 pandemic and the coverage of medicine in the media.

59. In local NHS medical management roles, I have also been a lead clinician and clinical/care group director during both my consultant appointments.

60. This length and breadth of experience and training means that although I have Never worked in the field of Paediatrics or neonatology, I do have a good all-round understanding of some of the issues this inquiry has asked me to consider, around culture, processes, workforce, policy, quality and safety of services.

61. In Summary: I am not a Paediatrician or Neonatologist or expert in these fields. However, alongside a long NHS career as a practising hospital doctor including 26

years as a consultant, I have played a wide variety of national leadership and policy roles and been a long standing policy commentator and medical writer and researcher. This has included work relevant to patient safety, audit and mortality.

Underlying structural and cultural Issues affecting NHS performance, workforce morale and retention and so indirectly affecting patient safety and care quality.

62. I will not give evidence specifically on the care of babies in Neonatal units or Paediatric Intensive Care, as I have spent my career in adult medicine and am not qualified to comment. However, there are some generic issues across NHS hospital care that pose risks to the safety and quality of patient care. And as the terms of the inquiry and lessons learned go beyond Neonatal Care specifically, I have deliberately alluded to some of the wider issues

63. I will signpost in Section 10 some key resources around neonatal care which the inquiry might choose to use but would be not able to comment with any authority on them, as I lack the requisite content expertise

64. I will list in this section some of the key structural challenges in recent years which have adversely affected NHS performance, capacity, resources, culture and morale. For those wanting to explore some of this in more depth there are number of published resources they might want to follow. In particular. The Institute for Government report 2023 "The NHS Crisis. Does the government have a plan" [2] And Professor Chris Ham for The King's Fund. "The Rise and Decline of the NHS in England from 2000 to 2020: How political failure led to the crisis in the NHS and Social Care" in 2023. [3] The joint Nuffield Trust and Health Foundation "Quality Watch" site with rolling updated resources describing and tracking NHS performance. [4]

65. Health Services in the 4 UK Nations and in particular in England have a very low bed base per 1000 people compared to nearly all other OECD nations. We have lost around half our hospital beds in the past 3 decades, even as admission numbers and age of patients admitted has risen and now only have 2.2 beds per 1000 people, and only around 100,000 General and Acute Beds for the 57 Million People in England. This risks ever increasing pressure on a shrinking bed base without radical action. [5,6]

66. Hospitals are now running at well over 95% midnight bed occupancy, leaving them with no headroom or flexibility for new admissions and dealing daily with a desperate struggle to find beds to admit patients to and to find patients whose discharge they can expedite [7].

67. This in turn leads to problems with flow through inpatient beds, to long waits, overcrowding and long handovers within emergency departments and consequent risk to patients [8]

68. This is compounded by a progressive rise in "delayed transfers of care" in patients who are technically fit to leave hospital but are stranded, waiting for access to step down community social and healthcare services, which have suffered cuts In recent years and lack the capacity to help those patients to leave hospital in a timely fashion [9]

69. Those same services can help to keep patients out of hospital but their lack of resource and staffing has affected their ability to respond quickly or help most people who could benefit [10,11]

70. Although the NHS was performing very well against national waiting time targets for Emergency Departments and ambulance response times by 2010, performance has steadily declined ever since and the NHS in England (and devolved nations) is now nowhere meeting those wait time targets it was able to meet a decade or more ago. [2,4] On February 8th, the latest NHS England Situation Report (SITREP) Data showing that in January 2024 alone, 12.4% of A&E attenders waited for more than 12 hours. Over 177,000 people. Over 1.5 million had waited more than 12 hours during 2023. [12, 13] Such numbers would have been unheard of a decade or so ago. Performance has declined steadily since. [2]

71. Over the past 30 years, the number of overnight maternity beds available has fallen by 20%, with numbers have fallen slightly since 2010/11 [14].

72. There has been no increase (in fact a fall of around 1,800 in numbers of Whole Time Equivalent fully qualified GPs since 2015 [15], around 1000 GP practices have closed in that time [16] and yet in the same period annual numbers of primary care appointments have risen to record highs [17] and there is a parallel crisis in the Practice Nursing and District Nursing Workforces with Health visitor and learning disability nurse numbers also falling. [18] NHS GPs see more patients per day than

those in a range of other high income nations and are correspondingly more unhappy and burnt-out in their work. [19,20]

73. It is fairly rare in the UK for elective or "cold" hospital sites to be separate from "hot" ones (dealing with urgent and emergency care and hosting major emergency departments) meaning that when there is a surge of urgent admissions, including those from a pandemic or seasonal respiratory virus, infection control issues and competing demands for care, then elective (planned) care gets cancelled. [21]

74. The Covid-19 Pandemic led to the cancellation or postponement of a great deal of elective care and despite government plans to reduce the size of the waiting list for elective care outpatient appointments, investigations, procedures and operations, we still have over 7 million people on waiting lists and have missed national wait time targets consistently for several years having been performing very well against those targets by 2010. [2, 13] On 9th February 2024, the Health Service Journal reported on the NHS England Data for Elective Care from December 2023 showing that 7.75 million people were now on waiting lists. 337,000 had been waiting for more than 52 weeks and 98,000 more than 75 weeks. [22] These kind of numbers represent a huge deterioration in performance since 2010 and which was worsening before the Covid-19 pandemic or any industrial action by doctors or other groups. [23]

75. A Nuffield Trust comparative analysis of the UK versus a range of other developed nations showed that whilst all had had to cancel or postpone elective care during the Covid pandemic, the NHS had been hit harder than most because of underlying structural weakness around capacity, investment and staffing. [24]

76. The NHS has spent consistently less in recent years than health systems in other industrialised nations on capital expenditure, with money repeatedly being allocated to short term revenue to keep services going. In turn that means that the state of NHS buildings, facilities, IT and equipment is often very poor or a risk to patient care. [25] The government's so called "Forty New Hospitals" programme has been widely criticised as no such thing and an arbitrary target. [26, 27] We have fewer scanners per 1000 people than most OECD nations [28] and there have been a series of failings around IT. This in turn impacts on productivity and staff morale

77. The NHS is already well down the OECD League Table of doctors and nurses per 1000 people [29, 30] but is facing a growing workforce crisis. There are significant

recruitment gaps across nursing, medicine and allied health professions and with record numbers of clinical staff either leaving the service or saying they are considering leaving. [31, 32} As of 2022 there were over 120,000 clinical vacancies in the NHS including over 40,000 nurses and over 8000 doctors. [33] And around half of all registered nurses in the UK are no longer working in the NHS. [34] Social Care also faces a major workforce crisis with around 1 in 9 posts now unfilled. [35] The Nuffield Trust NHS workforce tracker in February 2024

78. Published data from the Nuffield Trust Workforce Tracker [36] suggests there were 125,572 vacancies (9%) in the NHS between March and June 2023. However, this does not tell the whole story. The Trust also found that somewhere in the region of data based on around 50 NHS trusts suggest that in May 2021, an estimated four in five registered nurse vacancies and seven in eight doctor vacancies were being filled by temporary staff, either through an agency or using their 'bank' (the NHS in-house equivalent of an agency). However, some vacancies also remain unfilled by temporary staff, with our analysis suggesting that the NHS may have had some 1,400 unfilled doctor vacancies and around 8,000 to 12,000 unfilled nursing vacancies on a given day.

79. In addition, the Nuffield Trust also reported that other gaps in the rota might be caused by absences such as sick leave. During the peaks of the Covid-19 pandemic, the number of staff absent from work on one day reportedly reached over 120,000. [37] Despite sickness absences rising most dramatically during these periods, rates have remained consistently higher than they were pre-pandemic. The most common reason for absence is anxiety, stress, depression and other psychiatric illnesses, which led to an average of over 500,000 sick days per month in 2022.

80. Objective analyses from both the Nuffield Trust [38] and Financial Times [39] have shown significant real terms pay erosion across clinical professions over the past 15 years – both in comparison to the rest of the public sector and the wider economy.

81. The past 2 years have seen industrial relations disputes between unions representing nurses, doctors and allied health professionals and the government, with industrial action resulting.

82. The impact of working through the Covid-19 pandemic on staff wellbeing and sickness has been significant and was associated with high rates of moral injury among frontline

clinicians and a much higher rate than the general population of contracting serious Covid-19. [40,41]

83. The annual NHS Staff Survey is now showing lower levels of satisfaction than it has done since data reporting began. [42] The 2022 report (over 600,000 Staff Surveyed) showed that 3 in 10 were considering leaving. [43]

    a. 72% of survey respondents said that they worked in NHS organisations with "too few colleagues to allow them to do their job properly." Only 27% said that "staffing was sufficient" at their organisation, and only 68% were "happy with the standard of care their organisation provided." "Health and wellbeing" were significant concerns, and a third of doctors and dentists reported feeling burnt out from work.
    b. The 2023 NHS Staff Survey [210] results showed that only 70% of staff felt safe in raising concerns about quality and safety of care in their organisation or outside it and only around 50% felt those concerns would be acted upon. 28% said they had suffered physical or verbal abuse or discrimination in the course of their work from the general public and another 20% reported abuse or bullying or discrimination from bosses or colleagues.

84. A 2022 survey by unions representing them, of 2000 NHS clinical staff by who were considering leaving found that their main reasons were pay, their living and transport costs, and not feeling valued by the government or their employer. [44]

85. The Guardian reported on record numbers of NHS staff leaving the service in 2021-22 (170 000), [45] with workload, staffing gaps, stress, and pay all given as key reasons. A Financial Times analysis of why people wanted to leave the NHS showed "work-life balance" and "stress" as the top reasons [39]

86. NHS sickness days per annum have increased sharply in recent years with around 5% of staff now off sick in any given month. [46]

87. The declining satisfaction of the general public with NHS services mirrors that reported by NHS staff. We can track this through the annual analysis of the British Social Attitudes Survey [47,48] The 2022 report headlines were that:

88. Overall satisfaction with the NHS fell to 36 per cent – an unprecedented 17 percentage point decrease on 2020. This was the lowest level of satisfaction recorded since 1997, when satisfaction fell to 34 per cent. More people (41 per cent) were dissatisfied with the NHS than satisfied.

89. This fall in satisfaction was seen across all ages, income groups, sexes and supporters of different political parties.

90. The main reason people gave for being dissatisfied with the NHS overall was waiting times for GP and hospital appointments (65 per cent) followed by staff shortages (46 per cent) and a view that the government does not spend enough money on the NHS (40 per cent).

91. People remained supportive of the NHS model and of the NHS as an institution.

92. A 2 year joint research project by the Health Foundation and Ipsos Mori "Public Perceptions of Health and Social Care" with regular polling at intervals, has shown similar levels of dissatisfaction with services, similar priority issues and similar overall support for the NHS model. [49]

93. Focus groups run by "Engage Britain" have also highlighted serious public concerns over NHS performance [50]

94. The 2023 Report from the Institute for Government. "The NHS Crisis. Does the Sunak Government have a plan"? [2] sets out in some detail the decline in NHS performance since 2010 at which point across a range of indicators it had been performing well and describes the underlying structural causes around funding, staffing, investment, capacity, demand and population health

95. Professor Chris Ham's 2023 report for the King's Fund "The NHS in England from 2000 to 2020: Rise and Decline" [3] is also expertly illustrated with data and policy analysis

96. The wider NHS landscape I have described around shortages of capacity and staffing, underinvestment in facilities, declining performance, declining staff morale and declining public satisfaction may not be specific to neonatal services, but are crucial in

setting the scene and understanding the wider context for the cultural issues and relationships between clinicians and managers.

97. I don't want to comment specifically on Neonatal Units or Neonatology because that is not my clinical field. But in terms of impacts of the doctor-manager (or indeed clinician-manager more generally) relationship it clearly has the ability to improve or worsen patient safety

98. Staff wellbeing, retention and satisfaction impact on staffing levels and rota gaps and can help guard against "compassion fatigue" and "moral distress" or "moral injury". (where staff are traumatised by working regularly in an environment not resourced or staffed or with a sufficiently manageable workload) to deliver the standard of care they were trained or would like to). Levels of moral distress among NHS frontline staff are high currently.

99. We know that in turn these factors are significantly impacted by the quality of line management and by a compassionate organisational culture which values and supports staff.

100. Whilst national terms and conditions and real terms pay erosion are outside the gift of local managers, factors such as manageable workload, rota flexibility and gaps, target and actual minimum staffing levels, willingness to plug gaps with agency or locum staff, breaks, rest areas, on-site childcare, functioning I.T., good transport and parking, access to personal development and training, occupational health support and a culture that actively engages staff in improvement activities and feedback and gives good training opportunities to staff in rotational placements will al tend to improve culture and morale as well as recruitment and retention. [51]

101. And we know that there is a link between staffing, skill mix and patient safety, not least in nursing. [52]

102. Whilst I have said nothing specific about neonatal or paediatric intensive care unit services here and I am not qualified to make any expert comment, I have listed in Section 10, some sources of data about staffing, capacity and performance in those services.

103. In Summary: The NHS is currently struggling with its worst performance on access, wait times, response times, waiting lists, staff satisfaction, staff retention, patient and public satisfaction for many years. Facilities and equipment are also in a poor state and have been underinvested in. The Covid-19 pandemic has amplified and accelerated some of this and there are now ongoing industrial relations disputes. Staff are increasingly facing burnout and moral distress and there are ongoing concerns over the quality and safety of services and risks to patients. This is therefore not a conducive environment for an open and just culture, for learning from mistakes or preventing harm. Indeed, it may provide the conditions that make such problems more likely.

The importance of culture, governance, and management structures in the NHS to ensure the quality and safety of care and better working relationships between managers and clinical staff including doctors.

104. I have described in Section 2, some of the serious structural issues around resource, capacity and workforce which in turn pose a risk to the safety and quality of care and provide context for the relationships between clinical staff in direct patient care roles and managers (whether from clinical or non-clinical backgrounds)

105. But the way the NHS is directed and managed – from government through central agencies and down to trust boards, divisions and directorates also provides significant context for care failings and clashes of culture, within individual units or organisations.

106. NHS services in England and the devolved UK nations are not, contrary to assertions from some commentators unique in being largely publicly funded and publicly provided. Other nations including Spain, Italy, Portugal, Malta, New Zealand, Canadian Provinces and Scandinavian Nations have similar models. [53,54]

107. **Recent analysis and commentary from The BMJ [55] , The King's Fund,[56] Health Foundation [57] and Nuffield Trust [58]** has shown no especial advantage of multiple payer, social insurance or mixed funding models or models with a more marketized, multi-provider system of deliver over a more NHS style model, either in terms of outcomes or efficiency. And a greater convergence between those funding models, given that in insurance-based systems, the state has to carry much of the funding burden for groups with high levels of need or inability to pay, making the

debate falsely polarised. More insurance and market based systems also tend to incur greater transaction costs, management and administrative overheads.

108. However, those same expert health policy think tanks (56, 59] have agreed that where the NHS differs from other largely publicly provided, publicly funded health systems is the **degree of centralisation.** The others tend to have a great deal of control and resource and accountability devolved to regional agencies. The NHS, by contrast, despite various iterations of structural reorganisation notionally aimed at such localism (the latest, being the creation **of 42 integrated care boards(ICBs**) in England, [60] responsible for local populations of anything from approximately half a million to 3 million remains very centralised and very much in top down "command and control" mode and with a very strong element of oversight, performance management, financial control; operational direction, regulation or interference from Number 10, The Treasury Ministers, the **Department of Health and Social Care, NHS England Headquarters and its 7 regional officers and the Care Quality Commission.**

109. There are undoubted advantages of a centralised service – some notional or hypothetical but others realised in practice during the better periods of the NHS history. Centralisation allows for national workforce planning, national terms and conditions, national educational curriculae, exams and standards for professionals, national regulation of professions and of NHS providers. It allows for national guidelines and technology appraisals (for instance from **NICE**), national licensing of products and medications (from **MHRA**), national datasets on performance and outcomes, national clinical audits, national performance targets and improvement programme, national decisions on allocation of resources or prioritisation of particular services to reflect need. And it can mean that national politicians are held accountable for failings or improvements in services or allocation of resources to them.

110. However, there are downsides to this degree of centralisation. These include:

    a. The repeated imposition on to health and social care services of distracting re-organisations of national and regional arm's length bodies and lines of accountability, sometimes requiring primary or secondary legislation to accompany them and often the redistribution, hiring of firing of civil servants, management or administration staff. as set out in the **The Nuffield Trust "doomed to repeat"** analysis [61] the **NHS Confederation's "Conditions for Governing the NHS" Report** [62] or research work from multiple centres on on

the NHS and other health services as *a "complex adaptive systems"* [63,64] where all change has unintended consequences and more recent analyses of the endless "NHS Reform" narrative, [58,59] as well as **Timmins' analysis for the King's Fund of Andrew Lansley's 2012 health and care act "Never Again"** [65] have all concluded that structural reorganisation is often a distracting sideshow when services need stability and longer term predictability and institutional memory.

b. For all the talk of devolving decision making and oversight to regional agencies for local services, a relentless focus over many years on central "grip" over finance and performance management, demands of regulators, terms and conditions for staff and the need to hit a range of key performance indicators and demands driven from government and other central agencies and reinforced through NHS England Regional offices [62, 66, 67,68]

111. The pages of the **Health Service Journal** are full of articles detailing directives, controls, central targets and initiatives imposed on local NHS managers, often inadequately funded, imposition from central agencies of interim *"turnaround directors"* critical care quality commission inspections and special measures. And crucially, very few people posting on the responses to articles (many of them clearly in NHS senior management roles) feel able to post in their own names for fear of reprisal or threats to their own career.

112. **Dr Henrietta Hughes**, currently the **National Patient Safety Commissioner** but formerly the **National Freedom to Speak UP Guardian** and before that an NHS England Medical director and senior General Practitioner told the Health Service Journal in January 2024 that *"What needs to change is that [NHS] trusts are currently held accountable to a very narrow set of criteria — financial and operational performance,"* [69] (and so by extension, the criteria for judging their performance need to be broader)

113. She continued that *"leadership intent" to promote a culture of listening to patients and staff is important, with psychological safety and increased scrutiny by regulators such as the Care Quality Commission paramount."* It is perhaps no surprise in this environment that the **median tenure for an NHS Chief Executive** is only 4 years [70]

114. **The Chartered Institute of Public Finance and Accountability** reported concerns that senior NHS finance officers were being bullied into compromising their professional ethics. [71]

115. Very senior hospital executives were reportedly summoned to an **NHS Improvement** meeting about emergency departments' performance. The atmosphere was reported by several attendees to be hostile, with executives humiliatingly forced to chant, *"We can do this."* [72]

116. The **King's Fund's reports on the experience of NHS chief executives and finance directors** highlight a culture of huge, top-down pressure and of people being judged failures against undeliverable expectations. "Oppressive scrutiny" and "bullying" regulators were mentioned. [73,74,75]

117. As recently as March, 2024 the Health Service Journal reported that NHS England had told trust chief executive officers to hit emergency wait time targets this year or risk funding cuts. This is like telling executives to run the marathon faster or their shoes will be taken away. [211] An NHS England Board Meeting Paper by finance director, Julian Kelly in 2022 told trusts they must make £12bn savings over the next two years (despite all the usual pressures to maintain and improve performance). [212]

118. These cultures, incentives and national management structures place considerable pressure on NHS bosses at local level, not least in hospitals to focus on key performance indicators and central targets, delivery priorities, financial control and hitting key regulatory frameworks. This in turn reduces flexibility to focus equally on local quality and safety initiatives, or to be open and honest about care failings and risks to patient care such as the current problems with short and unsafe staffing, long elective waiting lists, crumbling buildings, overcrowding and long waits in emergency care, high rates of delayed transfers of care in patients fit to leave. There is a premium on reputation management, on good news, on failing to be "challenging" over the impact of government policy or national agencies.

119. We saw this writ-large during **Covid-19 pandemic peaks in 2020-2022** when central government communications teams put pressure on **local NHS communications teams** and trust leaders to avoid media comment, to play down bad news stories and so in turn to avoid even senior clinicians appearing in the media or raising problems

with issues such as lack of testing capacity, lack of **Personal Protective Equipment** or hospital acquired Covid-19 infection. [76, 77]

120. In February 2024, the Health Service Journal reported **an NHS England Review of the culture in the NHS Ambulance trust sector** [78,79] which concluded (reviewing 3 ambulance trusts) that hitting key performance indicators around waiting times had been repeatedly prioritised over addressing serious misconduct claims. Siobhan Melia who led the review said that *"competing pressures often lead to poor behaviours, with capacity prioritisation overshadowing misconduct management", adding: "Staff shortages and limited opportunities for development mean that any work beyond direct clinical care is seen as a luxury or is rushed." "Despite this, there is a clear link between positive organisational culture and improved patient outcomes"*

121. This culture and these systems and structures mean that in many cases, the pressure exerted on very senior managers at local level transmits down the line to senior and middle managers and hence to clinical staff.

122. The King's Fund reports entitled **'Culture and Leadership in the NHS' [80] and "Leadership in Today's NHS"** [70] further underline the differential perspectives of senior managers and frontline staff. They found that executive directors tended to feel more positive about the working environment and culture within their organisations than other staff, particularly nurses. The lack of a shared perspective in this arena is a cause for concern

123. **The Joint Royal College of Nursing/NHS Leadership Academy document "Trust: An essential ingredient for effective inclusive leadership in the NHS"** [81] highlighted problems in NHS organisations caused by a lack of trust between frontline clinical staff and managers, different priorities, agendas and drivers for the two groups and the importance of creating environments where there is sufficient trust for staff to raise concerns openly and without fear.

124. **My own investigative story for the *British Medical Journal*** in 2021 on PPE shortages during the Covid Pandemic and based on FOI requests to over 130 NHS trusts, cross-referenced with the **Doctors' Association UK** database of over 1,500 concerns raised by members showed both endemic, repeated silencing or warning of clinical staff raising concerns about PPE quality availability, shortages, individualised

risk assessment and personal safety and blanket denial from nearly every trust that PPE was ever restricted or staff were ever warned if they complained. [82]

125. The report and recommendations of the **Inquiry by Sir Robert Francis KC into the events at Mid Staffordshire Hospital** [83] also emphasised the need for an environment in which concerns can be raised openly and where there is a *"Just Culture"* with regard to issues around patient safety, quality, risk and harm. The government's response to Francis notionally embraced and supported the need for a *"No blame"* or *"Just" culture.* [84] And the subsequent creation of the **Health Services Safety Investigation Body (HSSIB)** [85] [85] drew on lessons from the aviation industry about such an open approach to investigating safety incidents or near misses.

126. **A Review of the impact of the Francis Report 10 years on by Martin et al from Cambridge University's Health Improvement Studies Institute (THIS)** in the *BMJ* [86] suggested that whilst awareness had been raised and recommendations made, accepted and committed to we still had considerable progress to make.

127. The paper included this paragraph "Among the most disheartening features of the post-Francis NHS are recurrent organisational catastrophes. Three aspects of this phenomenon are especially sobering. First is the repeated failure to identify promptly and intervene effectively in the worst of these events, linked to a persistent lack of valid and reliable measures for surveillance, early warning, and risk based regulation. Second is the NHS's ongoing difficulty in tackling problems of culture and behaviour, including the malign influence of individuals whose unacceptable behaviour and conduct create toxic working environments'. Third, and perhaps most dispiriting of all, is the disproportionate representation of vulnerable groups in these disasters, including maternity service users and infants, and people with learning disabilities. Failure to listen to the voices of patients and carers is a recurrent theme of investigations into avoidable harm - and one that the system seems incapable of heeding."

128. They went on to say "What can the NHS do to realise improvement and reduce the likelihood of further tragic events? Sustainable improvement is likely to rest more on achieving the spirit than the letter of Francis's recommendations. We suggest three overarching priorities. These need to start with listening. Psychological safety - a sense among staff and patients that it is safe to speak up without fear of retaliation or being undermined—is critical. But organisations that fail to hear and act will repeat their mistakes and suppress important sources of insight"

129. The Government-commissioned **Berwick Review into Patient Safety in 2013** also emphasised the importance of an open, blame free reporting and learning and a culture that supported this.

130. NHS England also has a confidential **"whistleblowers' support scheme**" and **guidance**. [88]

131. For all this intent, if we look at the findings of investigations from the **Francis Inquiry, Health Care Safety Investigation Branch,** Case studies from the **Freedom to Speak up Guardian's office ,** various reports **(for instance Morecambe Bay, Telford and Shrewsbury, Nottingham, East Kent) on maternity care failings,** the recent **CQC investigation** into a bullying culture at **University Hospitals Birmingham, or the Royal College of Surgeons report on University Hospitals Sussex,** the investigation into **care failings at Southern Healthcare NHS Trust** and many other reports and investigations into care failings, we find that a major factor was the silencing, intimidation or ignoring of staff raising concerns and a failure to listen to them.

132. Numerous cases of poor treatment of **NHS Whistleblowers** where the claims of the whistleblowers have subsequently been upheld, after damage to their employment, careers, income or reputation have also shown a similar pattern. The BMA has called for better protection of whistleblowers in law [89] as have senior nursing leaders [90]

133. This is not to say that bullying, silencing, intimidation, failure to listen to or involve frontline clinical staff is a universal, a norm in every organisation. Indeed the NHS staff survey [91] and other national employee surveys such as the **General Medical Council Training Survey** [92] show very big differences in staff satisfaction scores with regard to the organisations they work in, But for this inquiry, what goes wrong and why, in the organisations and services where things do go wrong is crucial.

134. As the respected and experienced patient advocate **David Gilbert** [93] argued in the **Health Service Journal in 2023** regarding the impact of public inquiries into health scandals and the recommendations that follow

    a. "*Having worked in both organisational regulation and with professional regulators (who have a very different history) it's my view we have an over-regulated system at the national level (let us for the time being ignore the resources issue).*

b. *This leads to overly bureaucratic local governance systems and creates an environment that makes it hard for leaders to be custodians of a patient-centred culture, even if they want to be.*

c. *There have been many calls for "right-touch regulation". Right-touch regulation means "understanding the problem before jumping to the solution". It makes sure that the level of regulation is "proportionate" and "agile".*

d. *Most reviews and inquiries nowadays only add to the mess. They call for more scrutiny, more people to do it, more complexity, more burden, more loss of seeing wood for trees. As a patient director, I spent much of my time copying and pasting text from one report to another to satisfy a dozen or so different sets of internal or external stakeholders."*

As Gilbert's article was entitled "The Letby Inquiry will not make any difference" it might be worth heeding his words and proving him wrong.

135. **In Summary: There have been any number of inquiries, investigations, reports and recommendations into care failings and culture in the NHS. There remain often excellent management teams and organisational or departmental cultures and often close working between doctors, other clinical staff teams and managers. However, we have a very centralised, top-down structure in the NHS which has persisted through any number of reorganisations and which often priorities financial "grip", regulatory standards and delivery of key performance indicators and targets and cascades down through regional offices and regulatory bodies. This in turn puts considerable pressure on executives and managers at local level and also makes it hard for them to speak out. And although some of the key targets and indicators and regulatory requirements are very much concerned with improving the safety and quality of care, sometimes they bring the values and priorities of managers into conflict with those of clinical professions, make it hard for managers to speak out and challenge national policy or take more control of local decision making and culture and often in turn make "Bad news" flagged by "challenging" clinicians unwelcome. Though sometimes clinicians themselves can resist service innovation and improvement initiatives, causing further frustration to managers.**

136. The selection, quality, training and oversight of NHS managers

a. I want to start this section by **defending and supporting NHS managers**. They have become an easy target for politicians' soundbites and for sections of the media. Repeated pledges are made to "slash bureaucracy" and "reduce the number of fat cat managers" (and divert the money to "frontline" clinical staff) and claims that the NHS is badly managed and inefficient, but the NHS – and any other modern health system does need high quality managers and non-clinical support staff in a variety of roles.

b. In **2015 Dayan et al for the Nuffield Trust found in the report "Fact or Fiction. The NHS has too many managers"** [94] that only 4% of NHS staff were managers and that this was a lower percentage than in other sectors of the economy or in health systems overseas, not least those with higher transaction costs and activity due to multiple payer/multiple provider, insurance and market based systems with a purchaser-provider split. This finding was reiterated in **2023 King's Fund comparison** [56] of funding and delivery mechanisms in various nations' health systems and in articles from **the Nuffield Trust and Health Foundation** advocating against a move to different funding models as a panacea for "reform". (54, 58]

c. The **2021 Commonwealth Fund "Mirror, Mirror" Report**, [96] despite reporting a declining performance for the NHS in several domains compared to earlier years, still ranked it very highly for "administrative efficiency"

d. **Professors Kirkpatrick and Malby from York and South Bank Universities published a series of evidence reviews in 2022 for the NHS Confederation** regarding the contribution of NHS management and managers. **"What do managers contribute?"** [97] "**Is the NHS overmanaged?**" [98] and **"What next for NHS managers?"** [99]

e. They found that NHS managers made up c 2 per cent of the NHS workforce compared to 9.5 cent of the wider UK workforce. In recent years the number of managers has been cut, at a time when the NHS is facing its biggest challenge. They concluded that the NHS as a whole is under, not over, managed. However, persistent and misleading media headlines continue to claim that the NHS is overmanaged.

f. Kirpatrick and Maltby also described he value that NHS managers add to NHS services and patient care. Efficiency, quality and patient satisfaction improve with an increase in management-to-staff ratios. Even a small increase in the proportion of managers employed (from 2 to 3 per cent of the workforce in an average acute trust) has a marked impact on performance. Clinicians working productively with managers in senior management teams and on boards have a clear impact on improved clinical outcomes.

g. They concluded that negative media and political narrative about NHS managers could result in policies which fail to develop management capacity in future and, in the process, exacerbate clinical workforce shortages and wider efforts to improve services.

h. The NHS was found to be spending around £640m per annum on NHS management consultancy in an FOI based story I wrote for the BMJ in 2014 [100] with central agencies also spending around £22m by 2019 in a further FOI based story. [101] Bychawski in 2023 described management consultants "raking in as much as £3,000 a day from the NHS". [102]. There was also a major spend on consultancy contracts during the Covid Pandemic highlighted by the **National Audit Office**. [103].

i. All this, despite **research from Warwick Business School and the Universities of Bristol and Seville** finding that NHS **management consultancy** was poor value for money and often worsened services. [104] and yet its use has been partly driven by the undermining of and cuts to NHS management capacity and the constant re-organisation of NHS organisational hierarchies and structures. [105, 106]

j. In ***BMJ Leader* in 2022** in an article regarding the constant **public attacks on NHS managers**, [107] Challans-Rasool and Williams said this:

"The lived experience of most healthcare managers is nothing like these lazy misrepresentations (although occasionally volumes of meetings can be a bit much) – their work feels urgent, important, and necessary – indeed essential. Their work in the operational delivery of services so patients can access their appointments, or hospital beds reliably, of managing and supporting staff wellbeing and development, of securing finance, of quality improvement, of

enabling improved productivity so more treatments can be undertaken and of securing sustainable investment for local people, is never done. There is always more to do, always greater demands from regulators, too few hours in the day and more often than not, little if any leeway in what must be done and when. Managers carry a huge sense of duty and feel heavy responsibility for their roles and outcomes, with usually few local peers for support, given the tiny proportion that managers make of the NHS workforce. Our managers often feel that they are on their own."

k. There is clearly an issue, which I have set out in **Section 3,** of senior managers in government departments or non-departmental arm's length bodies and their regional arms and in regulators because to an extent their roles are an artificial construct of the overcomplicated and constantly re-organising bureaucracy we have chosen to create rather than roles essential to the delivery of clinical services for patients. But most managers are not in those kind of roles

l. In any health service in any industrialised nation and in any funding or delivery model there are key management roles that will remain essential. These include roles in finance, payroll, human resources, estates, facilities, informational technology, logistics and procurement, engineering, legal services, education and training, and crucially in operational management roles from board through to divisions or care groups, to clinical directorates to individual services.

m. Crucially **(see Section 5) many employees with management roles and responsibilities are themselves registered clinicians** by background, often still practising clinically (especially doctor-managers) and often in management roles which, explicitly require clinical qualifications and registration – right up to board level, so that the "them and us" division between clinicians and managers is not quite so clear as sometimes presented.

n. In various high profile care failings, inquiries, investigations and reports, whilst executives and managers have received criticism, the cultural problems or poor behaviours have sometimes come from clinicians themselves. And in some examples of organisations which have transformed their culture and improved performance, including focus on patient safety, general managers have played a leading role. It has never been a simple binary of *"Managers bad. Clinicians good*".

o. **NHS management** is a very diverse profession with **diverse routes of entry** and no one standard pathway. There are various routes into NHS management roles. The NHS graduate management training scheme .Doctors, Nurses, Pharmacists and Allied Health Professionals who take on management roles – either those roles with a specific clinical designation and clear requirement for professional registration, or non-clinical roles open to other groups People with backgrounds in bespoke areas like finance, law, human resources, information technology, engineering, estates and facilities, education or research. People recruited from other parts of the public sector such as the Civil Service, Arm's Length Government Bodies, Armed Forces or Emergency Services People recruited from the Private Sector (whether health related or not).

p. With regard to **training of NHS managers.** . There is also the issue that there are no formal, standardised qualifications or courses required to become a senior NHS manager, albeit that many people appointed to these roles may have a range of relevant qualifications and experience and may have been trained by the **NHS Graduate Management Training Scheme**, [108] established in 1956 and now training around 300 people a year – with many former alumni going on to very senior NHS roles. . And others (for instance those working in finance or legal services or in designated clinician-manager roles) will have a formal set of qualifications and professional registration as absolute requirements for their role.

q. Most individual trusts or regional academic networks do offer a range of **personal leadership development programmes**, including those leading to **MBAs, other Masters' Degrees or Diplomas**, often in partnership with local universities. There are also **numerous courses** on offer at Higher Education Institutions, or via Health Policy Think Tanks, Clinical Royal Colleges or Faculties on leadership and management.

r. Organisations such as the **Health Foundation and its Q Community** [109] or the **National Quality Improvement Network** [110] or **Advancing Quality Alliance** [111] offer development programmes and learning networks in **Quality Improvement**

s. There is also an **NHS Leadership Academy** (part of the **NHS Workforce, Training and Education Directorate**) offering leadership and management training and development at several levels of seniority, [112] and a **Faculty of Medical Leadership and Management** [113] established in 2011 by medical royal colleges, faculties and the academy of medical royal colleges both of which offer courses and programmes. But there are **no standard requirements** and it is possible to get into middle and senior management roles, not least from a clinical background, without having had any standardised, universal, mandatory leadership or management bespoke training or personal development. The current landscape for training, qualifications and personal development in NHS managers is a confusing and inconsistent patchwork.

t. This **contrasts sharply with requirements for senior clinical and especially medical careers** requiring a professional undergraduate and postgraduate qualifications, annual assessment. Rotational training, exit exams and final award of certificate of completed specialist training alongside full professional registration and regulation. The contrast can stoke resentment and suspicion around the difference in rules and requirements from graduate clinicians towards managers.

u. Personally, I would like to see, for each level of seniority, some kind of certification and standard requirement that an individual has received signed off and assessed training across a variety of core competencies. These could include areas such as

   i. The wider NHS policy landscape, organisational structures, regulation and financial flows and importance of health and health care across communities and organisation boundaries

   ii. Human Resources, Workforce Planning, Employment Law, Staff Wellbeing, and understanding of the work done by frontline clinical staff and time spent shadowing them

   iii. NHS Finance, Budgeting, Business Planning, Business Cases

iv. Process Mapping, Process Engineering, Quality Improvement, Use of Data to measure performance and improvement and to detect safety issues and evaluate the impact of change

v. Relevant Health Care Law for instance around consent, confidentiality and data, mental capacity, best interests decisions, negligence, workplace criminality and ethics, including requirements of professional regulators

vi. Understanding the role and organisation of and pressures for other organisations in the local health and care sector outside their own employer and the role of whole systems and healthy communities

vii. Medical and healthcare education and training and how they are delivered and supported

viii. Corporate governance and including duties of candour and transparency and responsibility for safe care and to listen to concerns raised by employees or patients about quality and safety of services and working lives and respond adequately to them. Complaint handling and safety incident investigation

v. Meeting these learning requirements could be tailored to that individual's existing professional background and some of them could be met via a personal development programme once in post but they should be required.

w. I would also want to see **annual appraisal and sign off and 5 year revalidation** for NHS managers, akin to what doctors registered with the General Medical Council [114] already have to undergo. This appraisal should as a matter of course include wide 360 anonymised feedback from staff at all levels especially lower down the hierarchy in departments or divisions or organisations they manage so that the appraisal is not just about hitting top down performance indicators.

x. My strong view and especially **relevant to this inquiry is that a major part of that appraisal should always be around creating a safe environment for frontline staff to raise concerns over safety and quality of care and staffing gaps, responding to any complaints or incident investigations that highlight endemic safety risks and acting on all those concerns.** If professional registration becomes a reality then I would want to see serious

action taken against any managers who suppress bad news, ignore concerns raised by staff or try to shut down or silence them. Remember that the NHS Staff Survey in 2022 and 2023 showed only half the staff who responded felt that if they raised concerns they would be acted upon and only around 70% felt safe raising concerns. [42, 210]

y. I realise that NHS managers at all levels are already subject to plenty of performance review and appraisal from their own line managers and are often held accountable for a whole range of performance indicators and organisational priorities. In some ways one could argue they are often more accountable and performance managed than many clinicians. But it is not standardised, there is no register, it is not enshrined in law or regulation and there is a danger that their success and career progression is based on government or corporate priorities that may not always be aligned with putting the quality and safety of patient care first, nor the welfare and safety of clinical staff, nor the duty of transparency and candour.

z. There have been any number of **government commissioned external reviews** and recommendations around NHS culture leadership and management, for instance from **Sir Stuart Rose in 2015** [115] and from **Tom Kark KC in 2019** [116] around "fit and proper persons" requirements for Board-Level Directors.

aa. The **Health Foundation** also produced its own (not government-commissioned) comprehensive and well-evidenced 2022 report **"Strengthening NHS Management and Leadership. Priorities for Reform"** [117]. This report emphasised the importance of NHS managers, the need to value and support them (however politically unpopular) and to give them more local autonomy, more training and development, a more manageable workload and a less uncertain and constantly changing policy environment.

bb. But the most recent government-commissioned review and report was from **General Sir Gordon Messenger in 2022**, whose specific remit was a focus on NHS management and leadership. [118] Of course the government are under no obligation to accept or implement the findings and recommendations of such inquiries and I am not convinced that there has been a firm commitment since 2022 to heed Messenger's recommendations. But here they are:

cc. **Messenger made 7 key recommendations**.

i. Targeted interventions on collaborative leadership and organisational values

ii. Positive equality, diversity and inclusion (EDI) action

iii. Consistent management standards delivered through accredited training

iv. A simplified, standard appraisal system for the NHS

v. A new career and talent management function for managers

vi. Effective recruitment and development of non-executive directors (NEDs)

vii. Encouraging top talent into challenged parts of the system

dd. **The Health Foundation** [119] welcomed the focus on culture but also called for NHS managers to be included in the NHS workforce plan – which has not subsequently happened) and for the government to accept and implement the recommendations – which has also yet to happen. Indeed the rhetoric from government ministers has continued to be hostile towards NHS management and towards equality, inclusion and diversity action despite clear evidence **(Nuffield Trust Workforce Tracker**) that the service still has a major problem with this issue in terms of equal treatment and opportunities for different staff groups.

ee. **Kirkpatrick and Maltby** as part of their 2022 **series of review for the NHS Confederation**, focussing on **"What next for NHS Managers**?" [99] called for the following key changes.

137. The habit of denigrating managers in the NHS is misplaced and counter-productive. At worst, it channels investment away from management and administration, forcing busy clinical professionals to pick up the slack, exaggerating the workforce crisis and preventing reform. The cumulative effects of this could exacerbate the workforce crisis and hold up much needed reforms in the NHS.

138. Policymakers should change the narrative about NHS managers, to view them as part of the solution. This could imply a commitment to increasing investment in managers to a level which is closer to the average in other sectors across the UK.

139. Linked to the wider People Plan, the NHS should develop a workforce strategy for the future employment and development of managers as an occupational group, including clinical leaders.

140. The NHS should invest in new data science management capabilities to support ongoing service improvement work. By strengthening in house capabilities, the NHS could reduce its (expensive) reliance on external management consultants.

141. Wider governance and regulatory demands in the NHS should be adjusted to empower managers and create more space for local innovation and service improvement.

142. In Summary. Managers are selected for the NHS from a diverse variety of entry points. Some have clinical qualifications and backgrounds and have worked up through the management ladder either in clinically-designated roles or management roles also open to non-clinicians. Some come from the NHS graduate management training scheme. Others from finance, law, human resources or from specialist areas like estates, facilities and information technology. Others are recruited from other parts of the public sector, government agencies, or from the private sector. Whilst managers are essential to good health services and their numbers have been cut in recent years and their role sometimes undervalued and disparaged, I would welcome some more standardisation in terms of training and competencies and knowledge they should have to demonstrate and be assessed and regularly appraised on. However, in my opinion, the biggest issue that NHS managers face is that the NHS structure is so top down, so "command and control" in its model that they are under tremendous pressure to implement government imperatives, including key targets and financial controls and regulatory standards and their survival in post often depends on this. This hierarchical structure also makes it hard for them to challenge and speak out openly on issues around safety and quality of care or to react sufficiently to problems raised by frontline staff about resource, workload, environment or safety. And the way they are judged and performance managed makes such a transparent, outspoken, honest and challenging approach difficult for them to adopt and yet remaining in post. Their role is also

severely constrained by resources and workforce gaps and those numerous, often clashing, central imperatives.

143. The calls for statutory registration and regulation of NHS Managers. How useful and feasible a protection would this be?

a. Over the past few years there have been a number of calls from leaders of national bodies, politicians and policy commentators for NHS managers to have the same kind of statutory registration and regulation as doctors, nurses, pharmacists, allied health professionals and other professions outside the NHS

b. In the wake of the Lucy Letby verdict, **NHS England Chief Executive, Amanda Pritchard** said on the record that it was *"Time to look again"* [120] at regulation of NHS managers and the ability to disbar them and promised to revisit and examine this issue although there is, as yet no pledge from government ministers to legislate for regulation of managers. She and other senior **NHS England directors** also wrote a **letter to all the executives of NHS organisations** reinforcing the need to adhere to **"Freedom To Speak Up"** protections, to implement the new **Patient Safety Incident Framework** and to ensure they applied the **"Fit and Proper Persons Test"** for board directors. [121]

c. **The Kark Review in 2019** [116] of that **Fit and Proper Persons Test,** commissioned by the Department of Health and Social Care called for that test to be strengthened and made **7 recommendations** including developing competencies for directors, making a central database of directors' qualifications, training and appraisals and expanding the definition of serious misconduct. Kark stipulated these as reasons to disbar NHS directors and chairs

144. A person who has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which if committed in any of the United Kingdom, would constitute an offence.

145. A person who has been erased, removed, or struck off a register of professionals maintained by a regulator of health care or social work professionals.

146. An undischarged bankrupt, or a person whose estate has had a sequestration awarded in respect of it and who has not been discharged.

147. The subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland

148. A person whom a moratorium period under a debt relief order applies under Part VIIA 9 debt relief orders) of the Insolvency Act 1986(40)

149. A person who has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it.

150. Included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland

151. A person who has been responsible for, privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity, or discharging any functions relating to any office or employment with a service provider.

    a. NHS England has subsequently updated the **"Fit and Proper Person's" Framework for Trust Board members** and it comes into force in 2024 (213)

    b. In 2023 in the wake of the Letby Verdict, **The Patient Safety Commissioner for England** that she would welcome an Accredited Register of senior leaders in health. [122]

    c. I believe that **The Nolan Principles** [123] for holders of senior public office first published by the government in 1995 but still applicable, should also be adhered to by senior NHS managers at local and national level, although there is no consistent mechanism or legislation to enforce this adherence. Those principles are:

        i. Selflessness
        ii. Integrity
        iii. Objectivity

iv. Accountability
v. Openness
vi. Honesty
vii. Leadership

d. In 2023, the **Professional Standards Authority for Health and Social Care** stated [124] *"We are eager to support collaborative efforts to address risks to patient safety by working together to find appropriate solutions. We would encourage policymakers to consider the full range of tools available to manage the risks, which may include reviewing existing mechanisms, or asking whether action is needed to improve their effectiveness, in addition to possible registration and/or regulation models*."

"We will work with the four UK Governments, NHS bodies and stakeholders UK-wide to understand where the risks and issues lie and to propose solutions to protect the public."

e. The **Labour Party** has promised that if elected, it would **legislate for the statutory regulation of NHS managers.** [125]

f. There have been similar public calls in Wales, and a Senedd discussion for regulation of managers after failings in health boards. [126]

g. In a members' surveys of the Union "**Managers in Partnership"** in 2018, 90% of senior managers surveyed (only 80 in total) [127] said they would welcome registration and regulation. Then in 2023 they surveyed (albeit only 291 respondents) of managers working at Agenda for Change Pay Band 8a or above, over half supported the principle of statutory regulation, despite concerns about the detail and risks of implementation and the fear of unfair regulation. [128]

h. Asked whether they "*in principle… support professional regulation of NHS managers",* 49 per cent said they supported or strongly supported it. Just 19 per cent said they opposed or strongly opposed, while the remainder were neutral.

i. However, respondents – 22 per cent of whom said they were already covered by a professional regulator, and likely to be nurses, doctors or finance or legal professionals – appeared sceptical about the benefits.

ii. Asked whether they thought professional regulation of NHS managers would make processes for raising concerns/whistleblowing better or worse, only 26 per cent said it would be better.

iii. Twenty per cent said these would get worse, and the remainder said it would be *"about the same".*

iv. There are also concerns about implementation.

v. More than 60 per cent of managers were *"not so confident"* or *"not at all confident"* that this regulation would be administered in a "fair, independent and proportionate" way.

i. In a column for the **New Statesman**, [129] *"Regulating NHS managers is not the silver bullet to a safer NHS",* **Jon Restell** the organisation's Chief Executive set out some arguments against the notion of regulation as some kind of *"silver bullet".* Although he does lead a Union with a particular professional vested interest, Restell has long experience in NHS management and his arguments are worth detailing here

j. The key planks of Restell's argument were

152. That many managers are already regulated by professional regulators for registered clinicians or finance professionals in management roles and yet that regulation has not proved a panacea or bulwark against poor practice or defence against serious care failings or cover ups

153. That the **Care Quality Commission** already looks at whether NHS organisations are well led, safe, effective, caring and responsive and poor CQC reports can force managers out, as can performance management pressure from NHS England or equivalents in the devolved nations.

154. That every NHS board member has to pass a **"Fit and Proper Persons Test**" which has in turn been strengthened recently by the **Kark Review**, which can disbar people

from taking on future director roles, much like the ability to disbar company directors or charity trustees outside the NHS

155. That professional regulation, GMC-style, would require a statutory framework that covers setting standards, registration and accreditation, revalidation and an independent body (emphatically *not* NHS England) to investigate and sanction professional managers who fall short. Those sanctions might include warnings and retraining as well as employment bars. But who would set the competency framework? Who would oversee and enforce it? And what account would be taken of the difficult circumstances in which many NHS managers find themselves in underfunded services in populations with high levels of need unmatched by resource and with poor capacity in local health and social services outside their own direct responsibility and which struggled to attract or retain staff. To what extent are individuals responsible or should they be personally accountable for failings?

    a. **A 2023 briefing by Annabelle Collins** [130] in the ***Health Service Journal*** reiterated these arguments and also emphasised that some of the biggest constraints around quality and safety – concerning staffing, capital expenditure or wider population health were outside the gift of NHS managers and regulatory action for issues they cannot personally solve but are ones in the wider system or wider policy context would be unfair to attribute to individual managers.

    b. Collins also argued that there was a risk that statutory regulation would be a public relations, tool offering "false reassurance" but might not address some of the thornier issues around whistleblowing concerns, clinical governance, patient safety, and perhaps how senior leaders are supported by regional and national teams to make difficult decisions – are not tackled, and within time, another scandal will emerge.

    c. Collins also pointed out that concerns in the wake of the Letby verdict about the Chief Executive and other senior managers moving to employment in other NHS Trusts would not have been stopped by statutory registration and regulation as they had been subject to no local disciplinary process or action, civil or criminal proceedings relating to the Letby case that might have led to any action from a professional regulator.

d. There are also concerns I often see expressed off the record or anonymously among the NHS management community, about any possibility of **NHS England** itself being the professional regulator. It already has a major role in performance management, setting targets and priorities, imposing financial controls and that some of those priorities come into direct conflict with those around safety, quality, candour and transparency at local level. It is already the line manager for local NHS managers, who have frequent pressure from NHS England Regional teams. And there would be a serious conflict of interest and a need for a regulator that was completely independent of NHSE.

e. I have set out a similar case against statutory regulation of managers as a panacea for wider safety and quality and cultural problems in the ***Health Service Journal*** [131]. My main arguments were as follows and mirror those set out above

156. Statutory regulation and registration tends to be for particular professions which require a standard set of undergraduate and postgraduate qualifications and a clearly defined body of knowledge and scope of practice. NHS management is far more diverse in terms of background routes of entry and qualifications than say being an NHS Consultant or Barrister, a Judge, an Accountant, a Teacher, Engineer, Actuary, Nurse, Pharmacist or Allied Health Professional. So for registration and regulation to become a reality, we would need the kind of standardisation suggested in the **Messenger Review**

157. Clinical and Finance professionals working in NHS management already have statutory registration and regulation and yet this has rarely been used against them in disciplinary terms or fitness to practice or conduct restrictions with specific regard to their management or executive roles.

158. The existing "Fit and Proper Persons" Test is rarely deployed to disbar NHS directors from further positions even in NHS trusts that appear to be failing or have had significant official censure, especially considering that the CQC only rates 74% of organisations as "well-led."

159. The Nolan Principles for holders of public office already apply to senior NHS managers and yet are rarely referred to in any kind of enforcement action.

160. There is already a Duty of Candour and Transparency in Section 20 of the CQC Regulations but it is relatively rare to see organisations held to account over this.

161. There are already official protections for whistleblowers and others raising concerns about care safety and quality, but they have not routinely protected those staff when they do raise concerns, nor landed senior managers in trouble when they have suppressed them.

162. Many of the failings in NHS organisations transcend the competence or integrity of one or two individual managers and lie in wider health and care systems locally, national policy issues for instance over spend or staffing, or historically in those organisations then inherited by current managers

163. The threshold (beyond gross organisational negligence or breaches of the criminal law or such egregious, persistent performance failings that individuals must be held to account) for placing serious restrictions on a manager's practice, ordering compulsory retraining, disbarring them from particular roles or from all roles and removing their livelihood and careers should be a high one, as it is for registered clinical staff.

164. Many failings in organisations or weaknesses in managers, fall well below the threshold of persistent incompetence or dishonesty

    a. Meanwhile, the **Care Quality Commission (CQC**) is an inspector and regulator of organisations, rather than individual managers and executives. Although poor CQC inspection reports can significantly damage the careers of senior managers or lead to their dismissal or departure, so do act as quasi-regulation and performance review of individuals.

    b. The CQC does oversee the organisational statutory duty of candour and "freedom to speak up" protections, relevant to this inquiry. **[See Sections 7 and 8].** Although the CQC's five inspection domains include "well-led" "safe" "responsive" "effective" and "caring", the judgements it makes and ratings it gives are not infallible and are not infrequently criticised.

    c. The CQC does specifically inspect children and young people's services including neonatal and paediatric intensive care. It has rarely enforced the protections around candour. And has sometimes rated organisations as "good"

and "well-led", where a care scandal was subsequently discovered to have been in progress.

d. In the **2016 CQC Inspection Report on the Countess of Chester**, the CQC rated services for children and young people as "good" and they scored "good" on 4 domains, only getting *"requires improvement"* on *"safety"* [132]

e. In that report, the CQC said regarding services for children and young people that "*We saw evidence that incidents were being reported and that information following clinical incidents was fed back to staff in daily safety briefings"* and that *"Managers had a good knowledge of performance and were aware of the risks and challenges to their service".* They did criticise nurse staffing levels for falling below the **2013 RCN Standards** on the children's unit [133] and below the **British Association of Perinatal Medicine (BAPM) Standards** on the Neonatal Unit. [134]

f. By **2018 the CQC Inspection Report** [135] rated the hospital as *"requires improvement"* overall and it only scored *"good"* on the *"caring"* domain. The CQC chose not to inspect services for children and young people at all on that visit despite the concerns raised in 2016.

g. There is already in place a "**Code of Governance for NHS Provider Trusts** [136] which was last updated in 2023. There is an explicit framework which senior NHS managers can already be notionally held to account for delivering. Though my suspicion is that they are far more likely to be held to account by **NHS England** and its **regional offices** for failing to meet a smaller range of targets, controls or imperatives and by the **Care Quality Commission** for failing to meet its regulatory priorities.

h. The **NHS England "Framework for Corporate Governance"** includes the following sections:

   i. Section A: Board leadership and purpose
   ii. Section B: Division of responsibilities
   iii. Section C: Composition, succession and evaluation
   iv. Section D: Audit, risk and internal control
   v. Section E: Remuneration

vi. Schedule A: Disclosure of corporate governance arrangements
vii. Appendix A: Role of the trust secretary
viii. Appendix B: Council of governors and role of the nominated lead governor
ix. Appendix C: The code and other regulatory requirements

i. It also explains that

165. "Trusts must comply with each of the provisions of the code or, where appropriate, explain in each case why the trust has departed from the code."

a. However, I am of the very clear personal view – one highly relevant to the Letby case and this inquiry - that if further regulation or registration is enacted then any managers found to be suppressing or ignoring concerns raised by frontline clinical staff about patient safety, or worse still threatening, silencing, marginalising or constructively dismissing them are not fit and proper persons for further NHS roles and if these actions are proven against them should not be eligible for further employment in the NHS at any level. Too many Whistleblowing cases, too many inquiries into serious care failings have identified this pattern of suppressive behaviour or bullying and deaf ears to bad news or concerns.

b. I completely understand that in a tax funded, resource constrained, politically accountable, centrally managed health system, NHS managers do have to balance issues like safety, support for staff and open and just culture against the need to deliver on key performance indicators, financial targets, government and regulatory priorities. I know that some of those targets and indicators (for instance waiting times and access to care and meeting some of the CQC inspection domains are compatible with improving patient safety and avoiding harm.

c. I also understand why, in the current climate, as public servants, NHS managers can feel constrained in speaking out openly to challenge national policies or highlighting consequent safety risks or admitting that the care in their own organisation is sometimes or often unsafe. And I understand the drivers to protect organisational reputation. But we need a different performance management and assessments and appraisal and appointments process where managers are rewarded and protected for transparency, openness, promoting a

just culture, supporting staff who raise concerns and ensuring patient safety and avoidance of preventable harm is a "first among equals" priority.

d. At the same time, I accept that some organisations and some localities in healthcare are especially troubled in terms of population health need, demography and deprivation, state of facilities and estates and difficulties of recruitment and retention. And I would not want to see committed experienced NHS managers who have previously worked in a challenged location and challenging locality excluded from appointment to jobs or labelled as failing.

e. However, in the context of this inquiry, I think if it is proven that a manager has been personally involved in suppressing or dismissing concerns raised by staff (including whistle blowers who have raised them outside the organisation), threatening or silencing those staff or engineering their constructive dismissal or non-disclosure agreements this should be a reason to disbar them from future appointments or at the very least trigger a detailed review of their conduct before an appointment is made. Such individuals and such behaviour should have no place in our health system and pose a risk to patient care and to staff wellbeing.

f. Everything I have said about managers working in local provider organisations or local commissioning boards should apply equally to managers working in NHS England at Regional or National Level (or their equivalents in devolved nations), national public health agencies and the Care Quality Commission. Their behaviour can impact decisions, culture, priorities and behaviours at local level.

166. **In summary, I am not against the statutory registration and regulation of NHS managers. There is also moderate support from managers themselves when they are surveyed. However, it is not a panacea for some of the problems identified in the Letby Case.**

a. **Firstly, because already a large number of NHS managers have clinical registration with a clinical regulator or have other professional regulators for instance for finance professionals. Yet this fact has rarely led to any censure or restrictions on practice for managers and executives who are already registered relating to bullying, silencing whistle blowers, suppressing or hiding bad news or failing to create and open, listening and**

just culture. So why would this be any different if managers had their own regulatory body?

b. **Secondly, because (rightly so in my view) the bar for level of incompetence or unprofessional behaviour or deceit required to disbar someone from future practice or place serious restrictions on their practice should be set high and failings in organisations often result from wider structural problems outside those managers' direct gift. I see no evidence in this or other high profile cases recently that the senior managers in post at the time would have been disbarred from some professional register before the events had occurred, due to previous poor behaviours.**

c. **Thirdly, because there is already considerable regulation, performance management and scrutiny for managers or directors. For instance from the CQC Regulation 20 on the statutory duty of candour, from CQC inspections, from the Governance framework for NHS Trusts and the NHS operating plan and key indicators, from annual appraisal by their own line managers and from the "fit and proper persons test". Yet these have not been a bulwark against care failings and patient safety scandals.**

d. **Fourthly, because statutory regulation and registration tends to be for professions with a clear and consistent set of qualifications and entry requirements and routes into NHS management are not standardised or mandatory. There would have to be consensus about who counted as a "manager" for these purposes.**

e. **Fifth because any regulator would have to be completely independent from NHS England which has a clear conflict of interest in having to deliver and performance manage central targets and objectives. I can certainly see the utility of regulation in preventing some rogue individuals who made egregious mistakes from going on to further senior jobs within the NHS but that will never be more than a handful of managers, most of whom do their best in difficult circumstances. My main plea is that any regulation has to make the creation of an open, transparent and just culture paramount, first among equals in the standards, so that staff or patients or families raising concerns are listened to, enabled to do so safely with no impact on their own careers and their concerns taken seriously.**

f. **Any attempt to silence or bully or constructively dismiss or force non-disclosure people raising concerns or whistleblowing or to cover up systemic care failings especially when there are risks to patient or staff welfare and safety should result in very serious action against those individuals. At the moment, in my view their performance is judged more harshly for failing to hit Government targets or controls and there is a culture of not admitting to bad news, openly unsafe levels of resource or staffing or risks to patient care or of senior managers acknowledging these issues or challenging Government or central agencies.**

167. The implications of Clinical Professionals working as Managers

a. I have been asked specifically to comment on this issue following articles I have written on the subject, not least in the wake of the Letby verdict. [1, 137] I will note again here that at the time of her criminal actions at the Countess of Chester NHS Foundation Trust, the chief executive and chief nurse and divisional director responsible for children's services were all registered nurses by background, the executive medical director a doctor and indeed the director of legal services a lawyer. All had professional qualifications and had at some point been on professional registers. Dr Susan Gilby, the Chief Executive who came in and inherited the fallout from the Letby Case and has also subsequently moved on is also a registered medical practitioner and experienced NHS consultant.

b. In reality, the distinction between so called "frontline" clinical staff and managers is not so clear and binary as sometimes portrayed in the media or in the rhetoric of politicians and campaigners. There are plenty of management roles that specifically and explicitly require or involve professional clinical qualifications, clinical registration and experience and in some cases (especially for doctors) continuing patient-facing direct clinical care. And the leadership and organisation of clinical services by clinician-managers is still a clinical role of sorts.

c. Nurses may become ward managers or shift team leaders, matrons, care group, divisional or board level nursing directors or lead specialist clinical teams. Pharmacists and Allied Health Professionals also become leaders and supervisors of teams or departments. Doctors take on roles such as department lead clinicians, clinical or care group or divisional directors or board level medical

directors but generally still also working for some of each week directly in patient care. Similar progression exists in primary and community care roles. Registered staff may also take on specific themed areas in an organisation, for instance around governance, safety, quality improvement, education and training, infection control, information technology etc.

d. People who started their careers as registered clinicians also often enter general management or executive roles that are not restricted to clinicians, do not require clinical registration and don't have "clinical" as part of their title or job description. **Kirkpatrick et al in 2021** found that around **15% of people in NHS management roles were doctors**, generally in hybrid roles alongside their clinical work. [140, 98]. **The NHS Providers and NHS Leadership Academy 2017 Report *"Clinician to Chief Executive"*** estimated in 2016 that around **1 in 3 senior NHS managers had a clinical qualification** – with nurses accounting for around two thirds. [141] I would guess that this figure has increased since. Many Chief Executives, chief operating officers divisional or directorate unit managers or site managers in the NHS are nurses or allied health professionals by background. It is far rarer for doctors to take on such roles, which do not require clinical qualifications or have "clinical" or "medical" in the title and are open to general managers too. Such jobs would make substantial ongoing medical practice difficult. [138] However, a small but increasing number of chief executives in the NHS are doctors, often having come via the role of Executive Medical Director.

e. There are some theoretical and practical advantages to having current or former clinicians in management roles. The core business of NHS organisations is the organisation delivery of clinical care for patients and as clinicians who have worked their way up through the professional ranks, they have lived experience and insider understanding of that world, of how clinicians think and behave and of the pressures on them. It may be easier for them to relate to clinicians and to "speak their language" and for them to have credibility with clinical staff.

f. The **research work of Professsor Amanda Goodall at City University's Bayes' Business School,** now summarised in her book **"The Power of Credible Expert Leaders"** [142] has shown across several sectors, including healthcare that credible technical experts tend to make better managers because of these factors. **Research that Goodall published alongside Baker from the**

University of Zurich, ***"Do expert clinicians make the best leaders?"*** [143] based on hospitals in 3 nations found that medical staff were more satisfied with their jobs, happier with the quality of their support and supervision and less likely to be considering leaving when their line managers were themselves credible, expert clinicians. Although simply being a clinician was not enough on its own as it required those with the right management and leadership skills.

g. We know [51] that supportive, empathetic, skilled, informed direct line management is a major factor in morale, wellbeing and retention of clinical staff and we could hypothesise that managers who have had similar training and experiences to them might have a better chance of providing this. Although there have been numerous instances in inquiries and reports into care failings, poor treatment of staff or poor organisational culture where people with clinical qualifications were very much part of the senior management team right up to chief executive. So merely being a clinician is no guarantee of credibility, competence or professionalism.

h. The wider movement towards "clinically-led organisations" [144, 145] where clinicians are given a major share of management responsibility, either working in close partnership with general managers and finance professionals or taking on the general management roles themselves is grounded in the idea that most of the decisions which affect how money is spent, how staff are deployed, how resource and capacity is used sit with clinicians and most of the spend is on the employment of clinicians. This model has been implemented in some organisations around the NHS. Though it does raise the issue of those clinical staff needing to acquire a range of different skills around management, leadership and finance, not conventionally taught in clinical training and take on a different kind of "accountability" – which centres around organisational performance, delivery of key indicators and priorities as opposed to accountability for decisions about the care of individual patients or the outcomes for patients in their service.

i. The advent of **"New Public Management Theory"** embraced by the government [146] and the **1980s Griffiths Report on NHS leadership and Management**, [147] pushed non-clinical general managers including those from the Private Sector or Civil Service as well as from existing NHS employees into services that had until then largely been run by clinicians with managers in a

more supportive or administrative role. There has been a subsequent power shift. **A Health Foundation Commentary** [148] concluded that "*The Griffiths report put an end to consensus management and raised the power (and salary) of the general manager while reducing the power of other groups. Opposition came from those groups that would lose power, such as public health doctors and nursing managers*"

j. In other sectors, for instance the armed forces, policing, school and university leadership, the civil service, it is still the norm for career professional practitioners to hold the senior formal roles.

k. Despite the clear potential theoretical advantages of having clinically trained staff in management roles, this has not always played out in practice. In any number of care scandals, inquiries, independent reviews, case studies or whistleblowing cases of organisations where things have gone wrong or the culture has broken, staff in clinician-manager/executive roles or general managers/executives with clinical backgrounds have been as guilty of threatening or silencing staff, failing to listen or act on their to their concerns, failing to create a safe space for those concerns to be raised and of bullying or unsupportive behaviour. Often, they seem to have put corporate priorities around reputation, "managing up" (to the trust board or central NHS agencies beyond) and delivery of key corporate targets, priorities and budgetary plans above other considerations. Indeed in many cases, their own job security, career progression or future employment prospects might be harmed by not doing so. And in such cases, they may have in effect "gone native" and no longer identify principally as an advocate for and ally of the shop floor clinical staff.

l. A further issue with clinicians becoming managers is that, just as with general managers, there is no formal, standard requirement for any kind of additional training or qualifications. A nurse, can for instance become a ward manager on the strength of interview and application but with no national minimum requirement for management, HR or leadership training and then find themselves managing 40 staff, 30 beds and responsible for an annual budget of £2m or so. That same ward manager might then progress to matron and then unit general manager without any standard requirements for management training or accreditation. The same applies for doctors and allied health professionals who take on management and service leadership roles.

m. There are a range of local and national personal development opportunities via NHS **[See Section 4]** trusts or academic partners or via national bodies like the **Faculty of Medical Leadership and Management** or the **NHS Leadership Academy** or via Universities or Health Think tanks or clinical royal colleges and plenty of clinicians as they enter more senior management will have additional management and leadership training and qualifications but it is in no way standardised or mandatory and it would be possible for a clinicians to enter fairly senior management roles with no postgraduate qualifications in management.

n. In the Lucy Letby case, it was noticeable that the Chief Executive of the Trust was a nurse by background, as was the Divisional Director overseeing Neonatal Care. The Executive Director of nursing was a nurse and the Executive Medical Director was a doctor and Director of Trust legal services a lawyer.

o. Yet in accounts given by Paediatricians of the responses to their raising concerns reported in a timeline of events reported in the Health Service journal and reported with direct quote from the paediatricians in other outlets. [149,150] the clinical or legal background of these individuals did not prevent them from allegedly warning them off or dismissing their concerns or blaming them for raising them. I also note that as incoming Medical Director, Dr Susan Gilby who then became the Trust Chief Executive told **The Guardian** in an interview that her predecessor (also a qualified and registered medical practitioner) recommended reporting those Paediatricians to the **General Medical Council** [151) for what he and other executives had regarded as inappropriate behaviour by the doctors in the way they raised their concerns.

p. The **General Medical Council's "Good Medical Practice" Guidance** [152] says this about **doctors in management roles** – again, using the word *"must."*

   i. **"Responding to safety risks."**
   ii. **Paragraph 75** says that doctors "must raise their concern" if patients are at risk from "inadequate premises, equipment or other resources, policies or systems." Paragraph 76 says that doctors in formal management and leadership roles *"must take active steps to create an environment in which people can talk about errors and concerns safely. This includes making*

sure that any concerns raised with you are dealt with promptly and adequately."

q. **The Nursing and Midwifery Council (NMC) Code** [153] states that

i. *"Employer organisations should support their staff in upholding the standards in their professional Code as part of providing the quality and safety expected by service users and regulators."*

ii. This would have clear implications for registered nurses in management roles from the executive nursing director downwards.

iii. As a nurse or midwife you "Must"

iv. *"Act without delay if you believe that there is a risk to patient safety or public protection "*

v. "To achieve this, you *must*: "

168. Raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices "

169. Raise your concerns immediately if you are being asked to practise beyond your role, experience and training.

170. Tell someone in authority at the first reasonable opportunity if you experience problems that may prevent you working within the Code or other national standards, taking prompt action to tackle the causes of concern if you can.

171. Acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so.

172. **Not** obstruct, intimidate, victimise or in any way hinder a colleague, member of staff, person you care for or member of the public who wants to raise a concern.

173. Protect anyone you have management responsibility for from any harm, detriment, victimisation or unwarranted treatment after a concern is raised."

    a. **The NMC Code** also states that as nurse or midwife in any kind of role managing others you "must" Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system.

    b. Further that to achieve this, you "must":

174. Identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first.

175. Support any staff you may be responsible for to follow The Code at all times. They must have the knowledge, skills and competence for safe practice; and understand how to raise any concerns linked to any circumstances where the Code has, or could be, broken.

176. At the time of writing this submission for the inquiry, **I have submitted FOI requests re the GMC and NMC** specifically about fitness to practice cases in the past 5 years concerning registered doctors or nurses and their practice as leaders and managers. If I receive a reply before giving oral evidence, then I will supply it to the inquiry.

177. In Summary. There is evidence from academic research on organisational leadership and management that technical professional experts who are trained and experienced in the "core business" of the organisation (in the case of the NHS, patient-facing clinical care) tend to make better line managers. They have credibility and understand the work and have done it themselves. There is also a good rationale for clinically-led organisations.

    a. Much of the spend is on employment of clinical staff and most of the key decisions on treatment, investigation, admission, discharge and review sit with clinicians and this in turn influences both organisational performance, spend and patient safety. So why not give more of that responsibility and accountability to clinicians? There have been some positive experiences around the world with this approach and in some other countries it is quite normal for board level executives to be clinicians.

b. **Around one in three managers or people with management roles are clinicians – some of them (mostly doctors) continuing with their patient-facing clinical practice. Some of them are in jobs that do not explicitly require clinical qualifications but are open to others. Some management roles right up to board level are explicitly clinical ones. However, it is important to select clinicians with the right aptitude for management and to ensure they are equipped with the right technical knowledge management and leadership skills and have appropriate training and support.**

c. **The mere fact of being a good or credible clinician is no guarantee of being a good or credible manager, even if it might be a "head start" in terms of managing clinical staff. Although regulatory codes of practice and professional duties are very clear that doctors, nurses and allied health professionals in management role have clear responsibilities about creating and enabling an open, just, listening culture which values and encourages staff concerns and puts patient safety and staff wellbeing front and centre, in reality, this has not resulted in much regulatory action.**

d. **And the fact that some managers have clinical backgrounds has proved no bulwark against behaviours such as silencing or ignoring staff members who raise concerns, burying bad news or failing to be open and transparent about care failings. In my view, there is a clear danger that once clinicians take on management roles (especially if they then give up all of their direct patient care clinical practice) they will prioritise corporate imperatives, hitting government performance indicators and "managing upwards" rather than outspoken patient advocacy or solidarity with frontline clinical staff. While I completely support the growth of clinician-managers it is no panacea and would not necessarily prevent a case like Letby's. During 2016 and 2017 the CEO, Director of Nursing, Medical Director and Divisional Director involved were all registered, qualified clinicians by background.**

178. **The Implications and Impact of the Duty of Candour and Transparency for Regulated Clinical Professionals and for NHS Organisations**

179. As a result of the recommendations made by the **Francis Inquiry** both the **General Medical Council** and **Nursing and Midwifery Council** introduced a more formal **"Professional Duty of Candour and Transparency"** for Doctors, Nurses and Midwives when there are mistakes, care failings and harms. [154]

180. Here is the wording - and the word "must" rather than "should" is important as it implies a firm statutory professional obligation.

    a. *"Every health and care professional must be open and honest with patients and people in their care when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. This means that health and care professionals **must**:"*

    b. *"Tell the person (or, where appropriate, their advocate, carer or family) when something has gone wrong.*

181. Apologise to the person (or, where appropriate, their advocate, carer or family)

182. Offer an appropriate remedy or support to put matters right (if possible)

183. Explain fully to the person (or, where appropriate, their advocate, carer or family) the short and long term effects of what has happened."

184. *"Health and care professionals must also be open and honest with their colleagues, employers and relevant organisations, and take part in reviews and investigations when requested. They must also be open and honest with their regulators, raising concerns where appropriate. They must support and encourage each other to be open and honest, and not stop someone from raising concerns."*

185. **The NMC Code** [153] states that nurses and midwives must

    a. "Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place."

    b. **"**Act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm."

c. "Explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers."

d. "Document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly."

186. The NMC Code goes on to say that nurses and midwives must "Act without delay if you believe that there is a risk to patient safety or public protection."

187. "To achieve this, they *must*: "

188. "Raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices.

189. Raise your concerns immediately if you are being asked to practise beyond your role, experience and training.

190. Tell someone in authority at the first reasonable opportunity if you experience problems that may prevent you working within the Code or other national standards, taking prompt action to tackle the causes of concern if you can.

191. Acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so.

192. Not obstruct, intimidate, victimise or in any way hinder a colleague, member of staff, person you care for or member of the public who wants to raise a concern.

193. Protect anyone you have management responsibility for from any harm, detriment, victimisation or unwarranted treatment after a concern is raised."

194. A **Joint Statement from the Chief Executives of Statutory Regulators of Healthcare Professionals** [155] said this.

a. *"The professional duty of candour is about openness and honesty when things go wrong. "Every healthcare professional must be open and honest with patients*

when something goes wrong with their treatment or care which causes, or has the potential to cause, harm or distress"

195. This duty is equally applicable to registered graduate clinicians who work as senior managers or executives or within national agencies

196. The **GMC** also issued **guidance to doctors** initially in 2016 [156,157] but then updated in the wake of the **Dr Hadiza Bawa-Garba Case** [158] (a doctor initially convicted of gross negligence manslaughter and removed from the medical register, but now reinstated) regarding working in units they felt were unsafe due to staffing or equipment shortages or unmanageable workloads. At the time of the patient death which led to her conviction, Dr Bawa-Garba had been working in a severely understaffed and overstretched unit with little support and yet this was not regarded as a sufficient mitigation for her mistakes.

197. This case and Dr Bawa-Garba's conviction and removal from the medical register (after the GMC had initially not decided to strike her off) led to doctors being concerned that they might find themselves in a similar situation. Given how endemic staffing shortages, lack of capacity, rota gaps, high workloads, broken equipment and unsupportive managers have become **(See Section 2),** the finding on the **CQC 2016 Inspection of Children and Young People's Services at Countess of Chester** [132] **[See Section 5]** that Neonatal staffing was below the levels recommended in national guidance and that the safety of children's services there required improvement. And given the finding on the latest national NHS staff survey [42] that only 26% of staff feel their unit is adequately staffed and only 65% are happy with the quality of care in their organisation, this remains highly relevant.

198. In essence the GMC advised doctors, rather than refusing to work in such an environment (which would be riskier still for patients left with no doctor) to formally report the unsafe working conditions up the line in order to highlight the problem but also protect themselves.[156]

199. **Simon Stevens**, then the chief executive of NHS England, said in a **speech to NHS Providers in 2017** [159] that: *"in a democratically accountable NHS, the public have a right to know . . . Our duty of candour requires us now to explain the consequences of our decisions, to help inform the difficult choices that will be made for the year ahead."*

200. **Regulation 20 of the Care Quality Commission Framework** (updated 2022) [160] differentiates the ***"Statutory"* Duty of Candour for NHS organisations** from the ***"Professional"* Duty of Candour** for **registered clinical professionals.** Regulation 20: Duty of candour is a legal requirement for health service providers to act in an open and transparent way with relevant persons when things go wrong in care and treatment. It applies to any unintended or unexpected incident that could or appears to have resulted in harm to a service user, as judged by a healthcare professional. The regulation aims to ensure that providers are honest and accountable for their actions and learn from their mistakes.

201. In its **Guidance** [159] on **Regulation 20**, the **CQC** says this *"The duty of candour is a general duty to be open and transparent with people receiving care from you. It applies to every health and social care provider that CQC regulates. The duty of candour requires registered providers and registered managers (known as 'registered persons') to act in an open and transparent way with people receiving care or treatment from them. The regulation also defines 'notifiable safety incidents' and specifies how registered persons must apply the duty of candour if these incidents occur"*

202. The CQC goes on to say that statutory duty also includes specific requirements for certain situations known as 'notifiable safety incidents'. If something qualifies as a notifiable safety incident, carrying out the professional duty alone will not be enough to meet the requirements of the statutory duty.

203. It then states that "**A notifiable safety incident** must meet all 3 of the following criteria."

    a. "It must have been unintended or unexpected."

    b. "It must have occurred during the provision of an activity we regulate."

    c. "In the reasonable opinion of a healthcare professional, already has, or might, result in death, or severe or moderate harm to the person receiving care".

204. I think the implications of this definition seem highly relevant to the Letby Case which is the subject of this public inquiry.

205. **The CQC guidance around Regulation 20 on the Duty of Candour** then discusses how the CQC enforces and regulates this duty:

206. The duty of candour is one of the fundamental standards – below which care should never fall. As such it is an area of regulation we pay special attention to. We do not investigate every notifiable safety incident – this responsibility lies with the provider. Our role is to regulate the provider and ensure it is fulfilling its responsibility to carry out all aspects of the duty of candour"

207. "But we will investigate specific notifiable safety incidents where we have concerns. We do not make judgements about the performance of individual healthcare professionals. In the event of a breach, our judgement will be on the registered person. They are the representative of the care provider"

208. "Every provider should be creating an environment that encourages candour, openness and transparency at all levels. Candour underpins a culture of safety; it is only when organisations are open and honest that they can effectively learn from incidents that cause harm and improve the care that people receive."

209. **The 2020 "First Do No Harm" Review** chaired by **Baroness Cumberlege** [161] said this regarding the **Duty of Candour**.

    a. *"Doctors have long had an individual professional duty of candour to be open and honest with patients if things go wrong, and this was reinforced with a joint statement from regulators of healthcare professionals in 2019.39 Health and social care professionals also have a contractual duty of candour in their employment contracts."*

    b. *"Unfortunately, these duties were not always adhered to, and a statutory Duty of Candour for NHS bodies was introduced in November 2014, 40 and expanded to all CQC-registered care providers in April 2015. 2.48 Failure to comply with this duty is a criminal offence, and CQC can take enforcement actions over any breach of the duty of candour."*

    c. *"However, the Professional Standards Authority (PSA) report that the regulators are not identifying duty of candour breaches or considering them as part of*

fitness to practise panels. The statutory Duty of Candour has not been entirely effective."

210. The report went on *"Barriers to disclosure in the health and care system are well recognised. NHS Resolution told us their perception was that 'there has been a move away from a blame culture towards a more open culture in the NHS, where mistakes are more readily admitted, reported and discussed without fear of reprisal. Despite efforts to facilitate the raising of concerns by healthcare professionals, such as the introduction of local Freedom to Speak Up Guardians we heard about a persistent culture of reluctance to speak out: 'There is an inherent conflict in the NHS now, as somebody who works in it – there's not an open forum for mistakes or errors or things going wrong. There's too much blame for individual clinicians and surgeons"*

211. At the time of preparing this written evidence**, I have submitted FOI requests to the CQC, NMC and GMC** asking them how many cases in the past 5 years of breaches in the statutory duty of candour (CQC) and Professional Duty of Candour (NMC or GMC) have led to disciplinary or enforcement action or public criticism or downgrading of ratings. **So far I do have a response from the CQC detailing 30 actions over the past 5 years against trusts for beaches of Section 20 and can make this available to the inquiry.**

212. I have submitted those questions outline in 7.20 because there is no public database I can identify where this information is clearly available. But my personal perception as an experienced NHS doctor, clinical leader and policy commentator is that such action has rarely been taken and such regulatory action is far more likely to be taken for reasons other than the duty of candour and transparency.

213. Perhaps more important than my opinion is that of Dr Henrietta Hughes, a GP by professional background who has been both an NHS England medical director, national Freedom to Speak up Guardian and is now the national Patient Safety Commissioner.

214. Dr Hughes told the Health Service Journal in January 2024, [162] in an article written by Emily Townsend entitled "Duty of Candour a tick box exercise for overworked leaders, says watchdog" that "*the bandwidth of senior NHS leaders is too full to improve culture" and that they were "resorting to "ticking the duty of candour box" instead of developing a "just and learning" culture".* She warned, on the record that

"the duty of candour — giving patients and families the right to receive open and transparent communication when care goes wrong — gets seen as a "bit of a tick box exercise, 'doc tick' as it's described to me, which is a bit depressing really".

215. Dr Hughes went on to say that *"What needs to change is that [NHS] Trusts are currently held accountable to a very narrow set of criteria — financial and operational performance,"*

    a. *"When all parts of the system, including the Department of Health and Social Care and arm's-length bodies, demonstrably model listening to patients and families and incorporate this into their strategies and culture, then we will see this filter all the way down to the front line"*

    b. *"This is how we will improve safety and experience, transparency, a just and learning culture, and improve morale."*

216. She also told the HSJ in 2023 in the wave of both the Letby Case and Cumberlege review, "leadership intent" to promote a culture of listening to patients and staff is important, with psychological safety and increased scrutiny by regulators such as the Care Quality Commission paramount". [163]

217. The online comments from people who are almost certainly senior NHS managers and clinicians below Emily Townsend's HSJ article [162] interviewing Dr Hughes are telling.

218. In December, **DHSC** launched a **Consultation into the Effectiveness of the Duty of Candour Policy**, amid ministerial concern about "variation" in how it is applied in some settings. [164,165]

219. So while both the professional duty of candour (for registered, regulated clinicians) and the statutory duty of candour (for organisations regulated by the CQC) are in the public domain and notionally binding, it is not clear that they are consistently applied or enacted, not least because there is still a culture of fear and of consequences for individuals or organisational reputation and because both clinicians and executives face so many competing pressures. Nor do they seem to apply to national agencies like NHS England or the Care Quality Commission or Department of Health and Social Care who have overall responsibility for funding, overseeing, and regulating services or for professional regulators like the GMC or NMC.

220. Clinicians and managers are not going to raise concerns up the line if every day is unsafe and not acted upon. They will worry about being open with patients/families if they don't feel their line managers will be supportive and they will end up being blamed as individuals for organisational failings. We don't have any kind of database to measure how often people are candid or how often they are not

221. What we do know is that in GMC/NMC cases or in inquiries, inquests, reports into care failings, a lack of candour and honesty and openness often remains a feature years after this duty was introduced

222. And we still have a culture whereby from NHS England and its regional offices down to boards and below, far too often bad news is suppressed, unsafe services are not admitted to and senior managers won't openly challenge issues around poor resourcing/staffing/risks and frontline staff may feel unable to speak up

223. So it is often left to lobbying groups, royal colleges (for instance the **Royal College of Emergency Medicine** about the serious risks and harms from long waits and overcrowding), speciality medical societies, faculties, national clinical audit programmes or health advocacy or patient charities or bodies like **Health Watch England.**

224. What would help most is an organisational culture and leadership that actively solicits, values and takes seriously all concerns raised by staff and learning from complaint, case reviews etc. instead of the relentless focus on a small number of performance indicators and reputation management.

225. But if we are going to move to statutory regulation for NHS managers, then failing to act in this manner, or suppressing bad news should be a serious misconduct issue and it should be crystal clear In employment contracts for frontline staff that any attempt to prevent them raising concerns will be a breach of that contract and this in turn might be tested in employment tribunals.

226. In Summary There exists both a professional duty of candour, set out by the General Medical Council, Nursing and Midwifery Council and other professional regulators which tells registered professionals that they "must" (not "should") raise concerns about risk to patient safety, about errors or harms to patients. It

also places an obligation on registered clinicians in management roles to create a safe environment for concerns to be raised and to listen to, investigate and act on concerns. There is a parallel statutory duty of candour for NHS provider organisations (set out in Regulation 20 of the CQC regulations) to be open and transparent about risks, harms and incidents. There is also a national patient safety strategy and national safety incident reporting framework. And a series of recommendations made in Baroness Cumberlege's 2020 review "Patients First and Foremost" about Safety and in the 2013 Berwick Review. There is also a national patient safety commissioner – currently Dr Henrietta Hughes. Dr Hughes herself recently described the statutory duty of candour as a "tick box exercise" which managers were too busy to implement properly. A failure to adhere to the professional the duty of candour does not seem to have been used much by regulators in disciplinary or fitness to practice proceedings and the immediate past chief inspector of hospitals admitted that as yet there was still a closed culture. Both organisational leaders and clinical professionals need to be supported to be genuinely candid and open. At the moment the duty can look more intent than action. And there is still fear that being open about problems will harm the careers of individuals and make life difficult for them

The impact of "Freedom to Speak Up" guardians and protections

227. Following the events at **Mid Staffordshire NHS Foundation Trust, Sir Robert Francis KC** was commissioned to undertake a **Public Inquiry**. [83,84] During this process, from speaking to NHS workers and from the evidence submitted to the inquiry, he found that staff had tried to speak up about their concerns, but that they had been ignored, or victimised as a result. This experience was not confined to Mid Staffordshire and a further report, ***Freedom to speak up. An independent inquiry into creating an open and honest reporting culture in the NHS***, was commissioned and published in **2015**. [166]

228. ***Freedom to speak up*** made recommendations, two of which were accepted by all NHS organisations and the Department of Health. [167] The report included principles and actions about the culture and practice in the NHS, the appointment of freedom to speak up guardians in NHS trusts and foundation trusts and a national guardian to lead this network, undertake case reviews and provide support and challenge to the system.

229. According to the **National Guardian's Office**, [168] over 1,000 Freedom to Speak Up Guardians and others in a speaking up role have been appointed in NHS trusts and foundation trusts, national organisations and arm's-length bodies such as NHS England, NHS Improvement, the Care Quality Commission (CQC), the General Medical Council (GMC), the Parliamentary and Health Services Ombudsman (PHSO) and independent sector providers. Guardians are helping to lead changes in the systems, processes and policies in their organisations to ensure that when workers speak up they are heard and the right actions are taken.

230. **Dr Henrietta Hughes**, when she was still the **National Freedom to speak up Guardian** in 2019, wrote an essay in a **Future Healthcare Journal** on her role and described the role of guardians, thus. *"Freedom to speak up guardians are an alternative route to speaking to a line manager or other supervisor for workers, including staff, volunteers, learners, contractors, leaders and others. Guardians come from a wide range of professional backgrounds and seniorities. Their role is independent and impartial. They work reactively and proactively. Guardians preserve confidentiality and ask about detriment. They thank workers for speaking up and listen to their concerns. These concerns are then escalated to the right person in the organisation and guardians ensure that the outcome of investigations is shared with the person who has spoken up*" [169]

231. According to the **National Guardian's Office Annual Report** laid before parliament for the year **April 1 2022 to March 31 2023** alone [170] there were 25,382 cases raised. The Guardian's Office tagline is "Speak up, Listen up, Follow Up"

232. The Guardian's Office Report says it is supporting healthcare workers in England to speak up about anything which impacts on their ability to do their job. It says it has strengthened the training and support it gives **Freedom to Speak Up Guardians**, to ensure that they meet the needs of the workforce in this complex and wide-ranging role.

233. The **National Guardian's Office report for 2022-2023** explicitly references the Lucy Letby case and says this.

    a. *"The events surrounding the terrible crimes of Lucy Letby are an important reminder of how vital it is for organisations to have a culture in which workers feel safe to speak up about anything that gets in the way of delivering safe and*

high-quality care. Managers and senior leaders must be welcoming of speaking up and be ready to listen and act on what they hear.

b. *"Freedom to Speak Up must be at the heart of our efforts to improve the culture, leadership and wellbeing of our healthcare workers."*

234. **Dr Jayne Chidgey-Clark, National Guardian for the NHS,** said **in remarks in the introduction to the report** that:

"This year we have had stark reminders of why all efforts to improve the Speak Up culture in health, including the Freedom to Speak Up Guardian route, are so essential for patient safety

235. The **Annual Report** features case studies from across England, illustrating the difference Freedom to Speak Up guardians are making and examples of how healthcare workers are being supported to speak up for patient safety and worker wellbeing. Case studies are included from: Dudley Integrated Care NHS Trust, East of England Ambulance Service Trust, East and North Hertfordshire NHS Trust, First Community Health and Care CIC and Leeds and York Partnership NHS Trust.

236. It would be churlish of me to disparage all of this work and I am glad that we do have this network of guardians in place and this central oversight, reporting and training function and some good examples of how the initiative can work in practice.

237. **Dr Henrietta Hughes**, formerly national freedom to speak up Guardian and subsequently national patient safety commissioner had said in the ***Future Healthcare Journal*** [169] also in the ***Health Service Journal*** in 2020 [171] that the guardian role had enabled staff to speak out with more confidence and freedom.

238. At the same time, there have been numerous, widely reported stories in the healthcare press and in employment tribunals of NHS staff who felt they had no option but to blow the whistle regarding concerns over patient safety, having exhausted other official routes and were then poorly treated. This treatment has ranged from warnings, disciplinary action including suspension, reports to professional regulators, termination of contract sometimes with non-disclosure agreements, constructive dismissal or termination of medical postgraduate training. Whilst it might be argued that these were extreme cases, they do demonstrate that the presence of the guardians is no panacea.

239. Indeed in the Letby Case itself, there were reported attempts by the paediatricians to speak up about poor or dangerous care [149,150] that might not have been well received, Guardian or no Guardian.

240. In 2022 a major multi-centre **National Institute for Health Research (NIHR) funded project** described the **impact of FTSU guardians and office across NHS Trusts**. **Jones et al "Implementation of Freedom to Speak Up Guardians in NHA acute and mental health Trusts in England. The FTSUG mixed methods study**" [172].

241. The work packages comprised a major literature review, structured interviews with the Guardians and organisational case-studies.

    a. It made a series of recommendations for successful implementation of the role and for further research but whilst it was able to identify some of the structural weaknesses around the role and the way it had been set up, it was not set up to describe the specific impact on safety culture across the NHS.

242. The 2020 publication of the government commissioned report **"First Do No Harm. The report of the Independent Medicines and Medical Devices Safety Review**" [161] led by Baroness Cumberlege, whose introduction to the report included this statement.

    a. *"We have found that the healthcare system – in which I include the NHS, private providers, the regulators and professional bodies, pharmaceutical and device manufacturers,– is disjointed, siloed, unresponsive and defensive. It does not adequately recognise that patients are its raison d'etre. It has failed to listen to their concerns and when, belatedly, it has decided to act it has too often moved glacially. Indeed, over these two years we have found ourselves in the position of recommending, encouraging and urging the system to take action that should have been taken long ago"*

    b. As the report focussed on potentially preventable harms to patients from medicines and medical devices, it remains relevant to the work of this inquiry.

243. A story I wrote for the **British Medical Journal in 2021** during the height of the **Covid-19 Pandemic** illustrated the mismatch between high level ambitions and reality when it

comes to staff feeling able to speak up and candour from senior NHS organisational leaders. [173,174,175]

244. I sent **FOI Requests** to 130 NHS trusts, eventually receiving 82 replies asking them

245. Had they rationed or restricted PPE (personal protective equipment) use?

246. Had they warned any staff for using too high a specification of PPE?

247. Had they warned or disciplined staff for speaking out about PPE shortages or specification?

248. Had they been investigated by the Health and Safety Executive (HSE) for staff deaths from Covid?

249. I compared the replies to my questions with a database kept by **the Doctors Association UK** (DAAUK) of incidents (around 2000 in total) where instances of precisely such things had been reported by their members.

    a. Only three trust admitted "yes" to even one of the questions – totally at odds with what DAAUK members were telling them

250. NHS England in response to a linked FOI request from me, denied any vetting of public communications on Covid by NHS trusts, even though several NHS Comms directors told me personally and off the record that there was considerable message control from the centre

251. Even the HSE itself, agreed to tell me how many trusts they had been into to investigate staff deaths from Covid-19 but not to name the trusts involved

252. We also know from a report by the RCP London that many individual staff did not receive personalised Covid risk assessments which might have informed their level of personal protective equipment or their clinical duties, despite official policies.

253. We also had repeated denials from the government during the pandemic that there were PPE shortages and misleading claims that a "ring of steel" had been placed round care homes.

254. Many more examples are available of denials from government agencies, Just for one instance, whilst the Royal College of Emergency Medicine has produced numerous reports for instance in January 2023 estimating the number of deaths each week in emergency departments due to overcrowding, corridor care, long ambulance handover times and long waits, for assessment and treatment [176] there is scant acknowledgement of this from central agencies and a lack of credible policy action to help tackle the issues, despite the data on wait times, staffing and bed occupancy all being in the public domain. [177]

255. Overall, neither the professional duty of candour on individual clinicians including those with management roles, nor the statutory duty of candour for organisations, nor the advent of **Freedom to Speak up Guardians** has led to a culture that is repeatedly open or where staff feel able to raise concerns about risks, harms and safety without worrying about repercussions for them, or their organisation or careers and where they will be supported and listened to. And staff who become whistleblowers are often still treated very poorly and finding themselves constructively dismissed, unable to progress, marginalised or having to resort to employment tribunals.

256. In 2021, National Guardian **Dr Henrietta Hughes** said as much in a self-penned article for the **Health Service Journal** "**Listening to the Silence. What does the NHS staff survey tell us about the freedom to speak up?**" [178]

257. **In Summary…I welcome the creation of a National Freedom to Speak up Guardians' Office and an army of local Freedom to speak up guardians throughout the NHS and the notional protection that freedom to speak up policies give to staff who raise concerns about risks, errors and harms. And it is encouraging to see the range of case studies set out by the Guardian's Office where the Freedom to Speak Up protection and office has enabled concerns to be raised. However, academic evaluation of the impact of this policy has proved inconclusive and there are numerous examples from before, during and after the Covid-19 pandemic, including reports into care failings in individual trusts, or failings in support and protection of NHS staff that show we still have a long way to go before staff feel confident in using freedom to speak up as a matter of course or confident that their concerns will be taken seriously and not damage their own jobs. . At the moment, the policy risks looking more like noble intent than concrete and effective action. And there is still fear that being open,**

outspoken and challenging about problems will harm the careers of individuals or the reputation of organisations and make their lives more difficult. We need a different environment and culture to make the ambition a reality.

The culture, legislation, regulations and systems around patient safety, avoidable incidents harms or deaths

258. With very specific regard to improving patient safety, learning from incidents and near misses, and implementing solutions and mitigations against further risk then time and again, the literature and the findings of numerous reports and inquiries tell us that we need

    a. **Good real time data that can capture incidents, near misses, harms, risks or help to draw attention to potential concerns.**

    b. A focus on **structured learning from events** e.g. root cause analyses and serious untoward incident investigations

    c. **An open and blame free or "just" culture** where staff feel psychologically safe in raising concerns and confident that concerns will be acted upon

    d. **An acknowledgement of problems raised and a commitment to take concerns seriously** and investigate them rather than dismissing those concerns, blaming or silencing the person raising them and labelling them as too challenging or awkward.

    e. All of this is clearly set out in resources like the **NHS England Patient Safety Incidents Framework,** [179] the **World Health Organisation Global Patient Safety Framework**, [180], the Recommendations of the **Government's 2013 Berwick Review into Patient Safety in the NHS** [181] or the 2020 **Cumberlege Review on the Safety of Medicines and Medical Devices.** [161] There is strong consensus on the key elements of improving patient safety, recognising incidents, near misses and harms and learning from them.

259. None of this is new. There is a wealth of peer-reviewed literature, expert commentary and a long list of reports and recommendations concerning these issues that I could also have quoted. I don't intend to go into it in great detail for the purposes of this

written evidence but have picked reports that were already commissioned or endorsed by the government or NHS England.

a. The question is how we can improve implementation of best practice.

260. The **2013 Report by Professor Don Berwick**, commissioned by the government "Improving the Safety of NHS in England: A promise to learn. A commitment to act" [181] is a very good starting point.

261. Berwick said that the *"problems we have identified"* included

a. Patient safety problems exist throughout the NHS as with every other health care system in the world.

b. NHS staff are not to blame – in the vast majority of cases it is the systems, procedures, conditions, environment and constraints they face that lead to patient safety problems.

c. Incorrect priorities do damage: other goals are important, but the central focus must always be on patients.

d. In some instances, including Mid Staffordshire, clear warning signals abounded and were not heeded, especially the voices of patients and carers.

e. When responsibility is diffused, it is not clearly owned: with too many in charge, no-one is.

f. Improvement requires a system of support: the NHS needs a considered, resourced and driven agenda of capability-building in order to deliver continuous improvement.

g. Fear is toxic to both safety and improvement."

262. He went on to recommend that "to address these issues, the system must:"

a. Recognise with clarity and courage the need for wide systemic change.

b. Abandon blame as a tool and trust the goodwill and good intentions of the staff.

c. Reassert the primacy of working with patients and carers to achieve health care goals.

d. Use quantitative targets with caution.

e. Such goals do have an important role en route to progress, but should never displace the primary goal of better care

f. Recognise that transparency is essential and expect and insist on it.

g. Ensure that responsibility for functions related to safety and improvement are vested clearly and simply.

h. Give the people of the NHS career-long help to learn, master and apply modern methods for quality control, quality improvement and quality planning.

i. Make sure pride and joy in work, not fear, infuse the NHS:

263. Berwick's 10 Recommendations were:

a. The NHS should continually and forever reduce patient harm by embracing wholeheartedly an ethic of learning.

b. All leaders concerned with NHS healthcare – political, regulatory, governance, executive, clinical and advocacy – should place quality of care in general, and patient safety in particular, at the top of their priorities for investment, inquiry, improvement, regular reporting, encouragement and support.

c. Patients and their carers should be present, powerful and involved at all levels of healthcare organisations from wards to the boards of Trusts.

d. Government, Health Education England and NHS England should assure that sufficient staff are available to meet the NHS's needs now and in the future. Healthcare organisations should ensure that staff are present in appropriate numbers to provide safe care at all times and are well-supported.

e. Mastery of quality and patient safety sciences and practices should be part of initial preparation and lifelong education of all health care professionals, including managers and executives.

f. The NHS should become a learning organisation. Its leaders should create and support the capability for learning, and therefore change, at scale, within the NHS.

g. Transparency should be complete, timely and unequivocal. All data on quality and safety, whether assembled by government, organisations, or professional societies, should be shared in a timely fashion with all parties who want it, including, in accessible form, with the public.

h. All organisations should seek out the patient and carer voice as an essential asset in monitoring the safety and quality of care.

i. Supervisory and regulatory systems should be simple and clear. They should avoid diffusion of responsibility. They should be respectful of the goodwill and sound intention of the vast majority of staff. All incentives should point in the same direction.

j. We support responsive regulation of organisations, with a hierarchy of responses. Recourse to criminal sanctions should be extremely rare, and should function primarily as a deterrent to wilful or reckless neglect or mistreatment

264. The **Cumberlege Review (2020) "First do no Harm" Report of the Independent Medicines and Medical Devices Safety Review,** [161] touched on similar themes.

a. These included listening to patients and acting on their complaints and concerns, a duty of candour and transparency, learning from complaints and incidents to prevent future error, the importance of good clinical guidelines and quality standards, good consistent data capture on outcomes (including harms and safety incidents), ***"collecting what matters"*** via databases, audits and registries, holding people to account for ensuring safety and quality were delivered and support for the work of a national patient safety agency in some form and a national patient safety commissioner.

265. The Review quoted the then **Chief Inspector of Hospitals at the Care Quality Commission – Professor Ted Baker** saying this *"'I have to say 20 years later it is very frustrating how little progress we have made. It's clear to me that we still have not got the leadership and culture around patient safety right. As long as you have that culture of people trying to hide things - then we are not going to win this.'*

266. Going back further to the **2010 Part 1 report of Public Inquiry into the failings at Mid Staffordshire NHS Foundation Trust** from chaired by **Sir Robert Francis KC** and the **2013 Part 2 Report** focusing on **wider structural and cultural problems in the NHS** that required attention to prevent recurrences of similar care scandals and made 292 recommendations [83,84]. The diagnoses of underlying cultural and structural problems and recommendations for action, cover similar themes.

267. Whilst **some commentators did criticise Francis** not only for the high number of recommendations but for what might seem like legalistic, regulatory and procedural solutions to what were often cultural or structural problems,[182] **The Government** did respond in 2013 with **"Patients, First and Foremost"** [183] which did accept in principle many of the recommendations, not least the "duty of candour."

268. The Government list of actions to take forward was themed under the **following headings:**

    a. **Preventing problems.**
    b. **Detecting problems quickly.**
    c. **Taking action promptly.**
    d. **Ensuring robust accountability.**
    e. **Ensuring staff are trained and motivated.**

269. As in other reports there was a clear focus on clear standards and guidelines around quality and safety, effective and consistent reporting of data, transparency and candour, learning from complaints, mistakes, incidents and harms, organisational leadership and on culture, which and regulation which gave due weight and priority to improving safety and avoiding harm, staff training, education and skills around safety. The government did not endorse every Francis recommendation with proposed actions though – for instance around regulation and registration of healthcare assistants or managers.

270. There have also been conversations in the healthcare policy and patient safety community in the wake of Francis and other reports around a **"no blame" or "just" culture** in improving patient safety and NHS England has published a "just culture" guide [184] to be used alongside traditional patient safety investigation methodology.

271. A **"Just Culture"** refers to one which focuses on openness, repairing harm, and designing safer systems rather than blaming individuals for their behavioural choices A just culture aims to achieve a fair and values-supportive environment for both patients and staff

272. **NHS England** also has a **Patient Safety Strategy** (last updated in 2022} [185] and frameworks and tools for patient safety reporting and investigation. There is also the office of the **National Patient Safety Commissioner** currently occupied by **Dr Henrietta Hughes.** [186] Although Dr Hughes had previously raised concerns that funding for her office [187] and resources was "too little to make the necessary improvements" to safety oversight. Her current inability to publicly consult on key issues — a final statutory requirement of her role — is an ongoing source of frustration and something she continues to press DHSC on.

    a. Her first term of office has largely focused on redress for people harmed by pelvic mesh and sodium valproate, with findings anticipated at the time of my preparing this evidence. [188]

    b. Going forward, Dr Hughes has said she wants to shape the role for future terms, with 2024 expected to involve early-stage development of Martha's rule (giving patients the right to a second opinion), and patient safety for training for board members — particularly NEDs — working with NHS Providers.

273. **The Health Services Safety Investigation Body [HSSIB**], created in 2018 and describes itself thus on its current website [189]

    a. *"We investigate patient safety concerns across England to improve NHS care at a national level. Our investigations do not find blame or liability with individuals or organisations. Information shared with us is confidential and protected by law. We are a fully independent arm's length body of the Department of Health and Social Care."*

274. **HSSIB** has carried out numerous investigations and reviews into services, sites or themes since its creation and was given additional powers in the 2022 health and social care act to access information, documents or premises.[190] Its reports make a series of recommendations for improving safety. And its methods include "practical and academic models and tools to help us better understand how patient safety incidents occur. This allows us to adopt a systems perspective that does not find blame or liability with individuals or organisations"

275. Once again, the focus is on understanding, analysis, root causes, evidence and recommendations for improvement, not on blame

276. **NHS England** does have a **National Patient Safety** Team who in turn produce many reports, resources and alerts even though the **National Patient Safety Agency** has now been abolished.

277. **The National Health Care Quality Improvement Partnership (HQIP)** with central government funding via NHS England, also runs a whole range of themed **National Clinical Audit Programmes** around particular services or conditions, via the **National Clinical Audit and Patient Outcomes Programme (NCAPOP)** and including **NCEPOD (National Confidential Inquiry into Patient Outcome and Death).**

278. **The National Institute for Health and Care Excellence (NICE)** is the arms-length National Health Service (NHS) agency that provides recommendations to the NHS in England and Wales on clinical practice and technologies that should or should not be used in the NHS. It produces clinical guidelines based on evidence reviews, technology appraisals and quality standards.[191]

279. **NHS England** hosts **"GIRFT"** the **"Getting it Right First Time"** Programme. A national programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change.[192]

    a. The programme undertakes clinically-led reviews of specialties, combining wide-ranging data analysis with the input and professional knowledge of senior clinicians to examine how things are currently being done and how they could be improved.

b. GIRFT is part of an aligned set of programmes within NHS England. The programme has the backing of the Royal Colleges and professional associations.

280. **NHS Resolution's Clinical Negligence Scheme for Trusts** [193] makes adequate risk management systems a condition of membership and can disbar organisations from membership if they show serious failings for instance over non-disclosure.

281. For adults and children in England, since 2017 there has been an NHS England **Learning from Deaths In the NHS Programme**, [194] where all deaths required discussion with a locally employed medical examiner or where indicated with the coroner's office. Hospitals are also required to conduct structured mortality reviews and a data dashboard to ensure that they are reviewing care and identifying any care failings towards the end of life.

a. The **National Quality Board (NQB) Guidance** [195] for this scheme requires providers to collect and publish quarterly information on deaths in your care, reviews, investigations and resulting quality improvement.

282. The learning from deaths programme was followed by the creation and expansion of **"Medical Examiner of Death"** roles in NHS trusts in England announced by NHS Improvement in 2019 [196] to provide independent scrutiny of all deaths.12 Wales has adopted a similar approach. Although it had first been legislated for in the **2009 Coroners and Justice Act.** [197] The medical examiners are generally doctors employed in the local system and depending on the size of the organisation and number of deaths to be examined there will often be a one or more deputy or assistant medical examiners. There is also a **National Medical Examiner and Regional Medical Examiners.**

283. In 2019, the **Chief Coroner's Office** set out **"Notification of Deaths Regulations"** which had come before parliament that year. [198] The guidance contained this statement.

a. *"The Regulations make clear that a registered medical practitioner must notify the relevant senior coroner (the senior coroner appointed for the coroner area in which the body of the deceased person lies) of a person's death if they come to know of the death and in certain types of cases. Hitherto there have been no such regulations and the circumstances of reporting of deaths by medical*

practitioners to coroners has varied across coroner areas. To address this some senior coroners have issued local guidance to medical practitioners within their area. As with immediate effect any locally issued guidance or direction should be withdrawn and the principles set out in this document used by all coroners to ensure greater consistency over death reporting."

284. **The Guidance Accompanying the Regulations** [199]. Said that that "*Guidance has been provided by the Ministry of Justice to registered medical practitioners. A link to that guidance is attached to this document along with the published regulations. As a result of this national guidance there should be no local guides to doctors as to reportable deaths, so as to ensure national consistency".*

285. *"To state the obvious, if coroners, based on reports of death, have a cause for concern about any possible issues in a hospital (and in due course, in the community) they should raise this with their local medical examiner, or the regional medical examiners (or the National Medical Examiner and the Chief Coroner) as appropriate and agree any action. Effective dialogue is key. Local reporting criteria should not be imposed by a coroner in order to deal with these sorts of issues".*

286. **The regulations say this regarding a duty to report cases to the coroner.**

a. "As a result of the Notification of Death Regulations a senior coroner should expect to receive notification of deaths in the following circumstances:

a. the registered medical practitioner suspects that that the person's death was due to

i. poisoning, including by an otherwise benign substance.
ii. exposure to or contact with a toxic substance.
iii. the use of a medicinal product, controlled drug or psychoactive substance.
iv. violence.
v. trauma or injury.
vi. self-harm.
vii. neglect, including self-neglect.

viii. the person undergoing a treatment or procedure of a medical or similar nature;

ix. or

b. *the registered medical practitioner suspects that the person's death was unnatural but does not fall within any of the circumstances listed in sub-paragraph (a);*

c. *the registered medical practitioner* –

i. is an attending medical practitioner required to sign a certificate of cause of death in relation to the deceased person; but

ii. despite taking reasonable steps to determine the cause of death, considers that the cause of death is unknown.

d. the registered medical practitioner suspects that the person died while in custody or otherwise in state detention.

e. the registered medical practitioner reasonably believes that there is no attending medical practitioner required to sign a certificate of cause of death in relation to the deceased person.

f. the registered medical practitioner reasonably believes that –

i. an attending medical practitioner is required to sign a certificate of cause of death in relation to the deceased person; but

ii. the attending medical practitioner is not available within a reasonable time of the person's death to sign the certificate of cause of death.

g. the registered medical practitioner, after taking reasonable steps to ascertain the identity of the deceased person, is unable to do so.

287. As I have pointed out throughout my written evidence, whatever official guidance, legislation, regulation, rules, guidelines, standards and data reporting requirements are in place, whatever dedicated teams, agencies, posts or improvement programmes, all

the best intentions will founder if organisations and systems are under-resourced, overstretched, if competing priorities and incentives and indicators put safety, reporting, learning and candour down the list of organisational priorities and values despite the lip service paid to them. There is a considerable infrastructure and considerable good practice guidance, resources and data capture systems already in place.

288. **In Summary. There is already a considerable body of evidence, guidelines, recommendations, national agencies, inquiry findings, reporting mechanisms, practice frameworks and audit programmes to measure, learn from and improve quality of care including patient safety and to learn from avoidable harms, serious incidents and deaths. We have the recommendations of the 2013 Francis Inquiry and Government Response, the 2013 Berwick Report, the 2020 Cumberlege Review, the work of the Health Service Safety Investigation Bureau and its approach to safety investigations and recommendations, a National Safety Strategy, NHS England Safety Directorate and Safety Commissioner and several national good practice guidelines and frameworks. There are national clinical audit and quality programmes funded and overseen by the Health Quality Improvement Partnership (HQIP). There is a national "learning from deaths" programme and a national medical examiner of deaths as well as an army of local medical examiners of deaths to scrutinise, discuss and advice on death certification and a national coroners' office and national guidance and legislation on referral to coroners. Not all of this apparatus was in place during 2016-17 when the murders and attempted murders Lucy Letby was convicted of took place. But it is very much in place now and could provide a useful protection and earlier learning around clusters of unexpected and unexplained deaths. Although it would have to be utilised properly. I do not believe the deaths in the Letby Case were referred to the Coroner at the time and even without all the current initiatives and programmes we now have in place that might have offered opportunities to learn and intervene, albeit this was an extreme case.**

Specific sources of information, data, guidance and standards relating to neonatology and neonatal intensive care units

289. As stated in **Section 1**, I am not in any way an expert in Paediatrics, Neonatology, Neonatal or paediatric Intensive Care and am not qualified to comment with any

authority or qualifications on those issues. However, I will share some resources, guidelines, sources of evidence or information that the inquiry might find useful. Though it would require *bona fide* content experts to contextualise it all and comment with any authority.

290. Because the killings for which Lucy Letby was convicted were in 2016 and 2017, some of the developments in policy, regulations, data collection or reporting which might potentially help to detect or prevent such problems more quickly in future were not in place at that time

291. I discussed in **Section 2** the overall state of play in the NHS in 2024 in terms of staffing, morale, resource, capacity, performance indicators, public and patient satisfaction. But I said nothing specific about paediatric or neonatal services or paediatric/neonatal intensive care.

292. Historically, **NHS England** collect and publish data **the number of PICU and NICU beds open and occupied** at England and individual trust level through their **SITREPs (Situation Reports)** and the time series stretches from 2012/13 to 2023/24 [200] Because it is management data it comes with a healthy data caveat on quality and coverage, and data items do change their definition from time to time – but those caveats are usually well highlighted in the data.

293. **NHS England** also has a clinically led **Neonatal Critical Care Transformation Group** [201] which contains guidance and service specifications.

294. **The Royal College of Nursing** published safe staffing benchmarking for children's wards. [133] And the **British Association of Perinatal Medicine Guidance** on optimal arrangements for local neonatal units and special care units in the UK [134]. I mention these because they were explicitly referenced by the CQC in its **2016 inspection of the Countess of Chester,** where services for children and young people were graded *"requires improvement"* on safety. [132] **[Section 5]**

295. **The King's Fund** in 2020 published a long, well evidenced descriptive explainer paper on **Intensive Care Capacity (including Paediatric and Neonatal Intensive Care)** in the NHS **"Critical Care Services in the English NHS"** [202]

296. The **Nuffield Trust in 2023** published an analysis on **Capacity in Paediatric Intensive Care Beds** in winter months **"are there enough intensive care beds available for children this winter?"** [203]

297. **The Royal College of Paediatrics and Child** Health publishes an annual report funded by **HQIP** of the **"National Neonatal Audit Programme"** [NNAP] [204] This does measure neonatal mortality and other outcomes does break it down by region and individual hospital trust and makes a series of good practice recommendations.

298. **The HQIP Funded MMBRACE ("Mothers and Babies: Reducing Risk through audits and confidential inquiries across the UK)** audit produces annual reports although again this does not focus specifically on Neonatal Intensive Care Units. [205]

299. The **General Medical Council annual "State of Medical Education and Practice in the UK"** report [206] sets out numbers of specialists, SAS doctors and training grade doctors across all disciplines, including paediatrics and neonatology.

300. The Letby Case and other recent care scandals and inquiries clearly illustrate the need to have robust systems in place for reporting and learning from deaths and for spotting concerning patterns in the data that might in turn lead to earlier detection of problems

301. **NHS England** has a **"Maternity and Neonatal Programme"** which reports regularly, has a range of guidance and standards service organisation and outcome data and section devoted to "Listening to women and families" – which is relevant to this inquiry. [207] It does publish quarterly data on infant, neonatal and still birth mortality rates which are in turn collected from individual trusts who therefore clearly have the data at their disposal in real time, albeit with a lag of a few weeks. [208]

302. As I mentioned in **Section 9**, For adults and children in England, since 2017 there has been a **National Learning from Deaths Programme**, where all deaths required discussion with a locally employed medical examiner or when indicated with the coroner's office. Hospitals are also required to conduct structured mortality reviews and a data dashboard to ensure that they are reviewing care and identifying any care failings towards the end of life.

303. **The National Quality Board** (NQB) **Guidance on "Learning from Deaths"** [199] requires NHS providers to collect and publish quarterly information on deaths in your

care, reviews, investigations and resulting quality improvement. Deaths of both adults and children should be reported, however, every child's death must be reviewed, and different review processes apply for adults and children.

304. The guidance goes on to say that **The Royal College of Physicians' Structured Judgement review (SJR)** methodology is intended for use in adult inpatients only. Infant or child (under 18) death reviews should be undertaken in accordance with statutory guidance, **"Working Together to Safeguard Children."** [208] The Department for Education's Form C should be used as a reporting template. This includes the small number of children who die on adult wards.

305. I mentioned in **Section 9** that national legislation and guidance effective from 2022 aimed to set a national standard for referrals to coroners and for discussion of cases with medical examiners and reduce local variation in practice. And I note that in the Letby case, despite the total number of neonatal and infant deaths being considerably lower than it is for adults, and despite some of the deaths being unexpected, the coroner was not consistently involved.

306. In 2021, ***Alandagady and Chisholm* in *Infant Journal*** published **guidance** (which has no statutory force but seems an interesting template) **on referral to the coroner of neonatal deaths**, and stating that there was huge variation at the time in practice from units that referred them all through to others where reporting was very patchy and that there remained uncertainty about which deaths to refer, although citing the chief coroner's guidance on (all age) deaths and mandatory referral – including "where cause of death is unknown" where death was "Unnatural, violent or suspicious"

307. Here are the recommendations they made in their paper, although I realise that putting them into practice would require buy-in from the wider neonatology community and from coroners and compatibility with any local guidelines. Nonetheless, I wonder whether referrals to the coroner's office, post mortems and inquests might have led to earlier detection and action in the Letby Case and I think the inquiry should consider the use of both "learning from deaths" and "structured review" data and coronial referrals.

308.

Scenario	Events	Outcome	Refer to the coroner?
Any scenario resulting in HIE	Fetal compromise, emergency delivery and resuscitation	Baby dies of HIE	Yes
Baby born in poor condition after normal labour	Signs of life but resuscitation unsuccessful	Baby dies	Yes
Planned home birth	Baby born at home or transferred in due to complication; significant resuscitation required	Baby dies of HIE	Yes
Extreme preterm birth (<25 weeks) or lethal congenital abnormality	Resuscitation not initiated; documentation of discussion with parents; clear plan for comfort care	Baby dies	No*
Complication of low-risk neonatal procedure, eg blood transfusion, ROP laser surgery	Complication of procedure	Baby dies	Yes
Complication of high-risk neonatal procedure, eg NEC surgery, PDA ligation	Complication of procedure; clear documentation of communication of risks	Baby dies	Yes, with clarity regarding death as a complication of procedure or a complication of underlying condition that the procedure failed to improve
Redirection of care, in conditions where HIE not suspected	Continuing full intensive care futile; full discussion with family and clear documentation	Baby dies	No*

TABLE 2 Recommendations for when to refer to the coroner in different neonatal scenarios. Note, staff should be familiar with the practice in their own setting as local guidelines might state that all cases must be discussed with the coroner. *Unless there are any parental concerns. If the parents express concern about the quality of any aspect of health care or about the decision-making process, even with babies receiving palliative care, the case should be referred to the coroner. Abbreviations: HIE= hypoxic ischaemic encephalopathy, ROP=retinopathy of prematurity, NEC=necrotising enterocolitis, PDA=patent ductus arteriosus..

309. In Summary. I am not qualified or trained in paediatrics, neonatology, paediatric or neonatal intensive care and have no bespoke expertise in those fields. However, I can see that there are in place two relevant national clinical audit programmes. The National Neonatal Audit Programme.(NNAP) And the MMBRACE (Mothers and Babies, Reducing Risk through Audits and Confidential Inquiries) Programme. There are service specification and staffing guidelines from the Royal College of Nursing and from the British Association of Perinatal Medicine. There are National Quality Board Guidelines on reporting and learning from deaths which also apply to children, infants and neonates. And legislation on indications for referring to coroners as well as expert professional guidance on referral. And guidance suggesting the use of safeguarding protocols for structured learning from deaths. There are regular national data reports on activity, capacity and staffing in Neonatal Units. The CQC inspects services for children and young people on its visits. NICE published good practice guidance on neonatal care and neonatal intensive care. NHS England has a "Maternity and Neonatal Programme" which is clinically led and reports regularly and the Royal College of Paediatrics and Child Health has a key role in setting standards. In short, there is no shortage of guidance, data collection, data reporting and national oversight which can be deployed to ensure and assure the safest possible care for neonates. The question is to what extent it is consistently

deployed and what factors prevent implementation or prevent problems coming to light and being acted upon in 2024 and beyond rather than the context in 2016-2018 in which Lucy Letby's crimes were committed and clinicians at the Countess of Chester were raising concerns about anomalous deaths and her potential role. This concerns takes us back to the issues raised in early sections about NHS resource and staffing constraints, culture, competing priorities and candour or lack of it.

310. References

1. Oliver D. A Clinician versus Manager Blame Game is a False Dichotomy. *BMJ* 25 August 2023. David Oliver: A clinicians v managers blame game is a false dichotomy - PubMed (nih.gov)
2. Institute for Government. S Hoddinott. The NHS Crisis. Does the Sunak Government have a plan? Jan 2023 NHS-crisis-does-government-have-a-plan.pdf (instituteforgovernment.org.uk)
3. Ham C. The King's Fund. The rise and decline of the NHS in England 2000 to 2020. March 2023. The Rise And Decline Of The NHS In England 2000-20 | The King's Fund (kingsfund.org.uk)
4. Nuffield Trust and Health Foundation. Quality Watch QualityWatch | Nuffield Trust
5. King's Fund 2021. NHS hospital bed numbers. Past, present, future. NHS Hospital Bed Numbers: Past, Present, Future | The King's Fund (kingsfund.org.uk)
6. Health Foundation. 2022. How many hospital beds will the NHS need over the next decade. How many hospital beds will the NHS need over the coming decade? - The Health Foundation
7. British Medical Association. Hospital beds data analysis. 2022. NHS hospital beds data analysis (bma.org.uk)
8. Nuffield Trust. Delayed Discharges from Hospital. 2023 Delayed discharges from hospital | Nuffield Trust
9. Royal College of Emergency Medicine Explains. Long waits and excess deaths. 2023 RCEM_Explains_long_waits_and_excess_mortality.pdf
10. British Geriatrics Society 2021. Right Time, Right Place. Urgent community based responses for older people. Right time, right place: Urgent community-based care for older people | British Geriatrics Society (bgs.org.uk)
11. Kings Fund 2024 February. Primary and Community Care needs to be at the Core of Helath and Care. Primary And Community Care Needs To Be At The Core Of Health And Care | The King's Fund (kingsfund.org.uk)

12. More than 1.5m patients in England waited at least 12 hours in A&E in past year | Hospitals | The Guardian
13. BMA NHS Backlog Data Analysis Updated February 2024 NHS backlog data analysis (bma.org.uk)
14. NHS Maternity Statistics, England - 2021-22 - NHS Digital
15. Pressures in general practice data analysis (bma.org.uk)
16. GP numbers fall again as NHS surgeries told they must see patients within two weeks (inews.co.uk)
17. Pressures in general practice data analysis (bma.org.uk) 2024 update
18. Falling short: the NHS workforce challenge | Health Foundation 2023
19. BMJ 2019. Performance of UK NHS with other high income nations. Performance of UK National Health Service compared with other high income countries: observational study | The BMJ
20. UK GPs suffering unsustainable workplace pressures (health.org.uk)
21. Oliver D. BMJ 2021. Could separating "Hot" and "Cold" sites work? David Oliver: Could separating NHS "hot" and "cold" inpatient sites work? | The BMJ
22. Findlay R Feb 9th 2024. Elective Waiting Times Rise again. Health Service Journal. Elective waiting times rise again | Comment | Health Service Journal (hsj.co.uk)
23. Scobie S. Nuffield Trust 2023. "Are strikes by healthcare staff impacting NHS waiting lists?"
24. Nuffield Trust. Health System Recovery from Covid-19. Lessons from other nations. March 2022 Health system recovery from Covid-19: International lessons for the NHS | Nuffield Trust
25. NHS Confederation "Investing to Save. The capital expenditure requirement for a more sustainable NHS in England. 2023 Investing to save | NHS Confederation
26. NHS: Key Facts And Figures | The King's Fund (kingsfund.org.uk) 2022
26. Oliver D. BMJ 2023. The "forty new hospitals" pledge was always a mirage. David Oliver: The "40 new hospitals" pledge was always a mirage | The BMJ
27. Allegretti A, Campbell D. "Broken Pledge over 40 new hospitals will leave NHS Crumbling. Ministers Told". Guardian 2023 Broken pledge over 40 new hospitals will leave NHS 'crumbling', ministers told | Hospitals | The Guardian
28. OECD Data. CT Scanners and MRI Scanners per 1000 population. 2022 Health equipment - Computed tomography (CT) scanners - OECD Data
29. OECD data Doctors per 1000 population. 2022 Health resources - Doctors - OECD Data
30. OECD data. Nurses per 1000 population. 2022 Health resources - Nurses - OECD Data
31. Revealed. 170,000 staff leave NHS in England as Stress and Workload take their toll. Guardian 2023

32. John Burn Murdoch Financial Times 2023. Pay rises alone will not stem the flow of Britain's medics (ft.com)
33. NHS: Key Facts And Figures | The King's Fund (kingsfund.org.uk)
34. Palmer W. Nuffield Trust. 2022. Peak Leaving. A spotlight on nurse leaver rates in the UK. Peak leaving? A spotlight on nurse leaver rates in the UK | Nuffield Trust
35. Skills for Care. The State of the Social Care Sector and Workforce. Updated October 2023 The state of the adult social care sector and workforce in England (skillsforcare.org.uk)
36. Nuffield Trust. February 2024. The NHS workforce in numbers The NHS workforce in numbers | Nuffield Trust
37. BMJ data analysis NHS staff sickness during Covid 2021 NHS sickness absence during the covid-19 pandemic | The BMJ
38. Nuffield Trust. Chart of the Week. What has happened to NHS pay since 2010? November 2022 Chart of the week: What has happened to NHS staff pay since 2010? | Nuffield Trust
39. Burn-Murdoch J. Financial Times 2023. Pay rises alone will not stem the flow of NHS medics Pay rises alone will not stem the flow of Britain's medics (ft.com)
40. M Deakin. BMJ 2022_NHS workforce shortages and staff burnout are taking a toll | The BMJ
41. J Best. Undermined and Undervalued. How the pandemic accelerated burnout and moral injury in the NHS workforce. BMJ 2021 Undermined and undervalued: how the pandemic exacerbated moral injury and burnout in the NHS | The BMJ
42. The King's Fund. 2023. The NHS Staff Survey 2022. What do the results tell us? The NHS Staff Survey 2022: What Do The Results Tell Us? | The King's Fund (kingsfund.org.uk)
43. Bawden A. Guardian 2003. 3 in 10 NHS Staff thinking of quitting, survey finds. Three in 10 NHS staff in England often think of quitting, survey finds | NHS | The Guardian
44. Royal College of Midwives 2022. Four out of Five NHS staff say pay is the main reason they would quit their jobs. Four out of five NHS staff say pay is main reason they would quit their jobs (rcm.org.uk)
45. J Ungoed-Thomas. Guardian 2023. Revealed. 170,000 NHS Staff quit their jobs as stress and workload take their toll.
Revealed: record 170,000 staff leave NHS in England as stress and workload take toll | NHS | The Guardian
46. NHS Sickness Absence Rates, September 2023, Provisional Statistics - NHS Digital. January 2024
47. The King's Fund. Public Satisfaction with the NHS in 2022. Repcumerort of British Social Attitudes Survey, Kings Fund 2023 Public Satisfaction With The NHS And Social Care In 2022 | The King's Fund (kingsfund.org.uk)

48. Nuffield Trust. 2023. Public Satisfaction with the NHS and Social Care in 2022. Results of the British Social Attitudes Survey Public satisfaction with the NHS and social care in 2022: Results from the British Social Attitudes survey | Nuffield Trust
49. Health Foundation and Ipsos Mori Survey 2023. Public Perceptions of Health and Social Care. Public perceptions of health and social care - The Health Foundation
50. Engage Britain. 2023. The Public's View on the NHS and Social Care. The British public's views on the NHS and social care (engagebritain.org)
51. Oliver D. BMJ 2024 Work Wellness Programmes aren't the key to improving retention. David Oliver: Work wellness programmes aren't the key to improving NHS morale or retention | The BMJ
52. Amiri A. Nursing Graduates and quality of acute hospital care in 33 OECD Countries. Evidence from Linear Models. Sage Open Nursing 2021. Nursing Graduates and Quality of Acute Hospital Care in 33 OECD Countries: Evidence From Generalized Linear Models and Data Envelopment Analysis - Arshia Amiri, 2021 (sagepub.com)
53. Edwards N. Nuffield Trust 2018 "why has the NHS not been copied"? Spoiler. It has. Why has the NHS not been copied? (Spoiler: it has) | Nuffield Trust
54. Edwards N. Nuffield Trust 2022. Myth Three. "We should copy other countries and adopt a social insurance model" Myth #3: "We should copy other countries and adopt a social insurance model" | Nuffield Trust
55. Crisp N et al. BMJ 2024. The NHS founding principles are still appropriate today and provide a strong foundation for the future | The BMJ
56. The Kings Fund 2023. How does the NHS compare to health systems of other countries? How does the NHS compare to the health care systems of other countries (kingsfund.org.uk)
57. Nuffield Trust Health Policy Summit 2023. Diagnosing the NHS. Nigel Edwards. Summit 2023 session: Diagnosing the NHS (youtube.com)
58. Alderwick H. Health Foundation. 2021. Big Picture. A close look at health system reform. Big picture: a closer look at health system reform - The Health Foundation
59. Edwards N. Nuffield Trust. Myth two. The NHS is a sacred cow that evades reform. Myth #2: "The NHS is a 'sacred cow' that evades reform, and its exceptionalism is its weakness" | Nuffield Trust
60. Charles A. King's Fund. 2022. Integrated Care Systems Explained | The King's Fund (kingsfund.org.uk)
61. Nuffield Trust 2018. Doomed to Repeat. Lessons from the history of NHS Reform. Doomed to repeat? Lessons from the history of NHS reform | Nuffield Trust
62. NHS Confederation. Governing the NHS and Social Care System in England, Conditions for Success. 2022 Governing the health and care system in England | NHS Confederation

63. Complex adaptive systems - The Health Foundation 2010
64. Ham C. For The Q Community, Health Foundation and NHS Confederation. Improving Healthcare at Scale. Learning from the Experience of Systems 2023 Complex adaptive systems - The Health Foundation
65. Timmins N. King's Fund. 2012. The story of the Health and Social care Act 2012. Never Again? | The King's Fund (kingsfund.org.uk)
66. Mannion R et al BMJ 2023. The power of autonomy and resilience in healthcare delivery. The power of autonomy and resilience in healthcare delivery | The BMJ
67. David Oliver: Is England's NHS too "top down"? | The BMJ 2022
68. Oliver D. BMJ 2022. We need a statutory duty of candour for NHS executives. David Oliver: We need statutory duty of candour and transparency for NHS executives | The BMJ
69. Townsend E. Duty of Candour a Tick Box Exercise for overworked leaders, says watchdog. Health Service Journal January 2024. Duty of candour a 'tick box exercise' for overworked leaders, says watchdog | News | Health Service Journal (hsj.co.uk)
70. Anandaciva S et al 2018. King's Fund. Leadership in today's NHS. Leadership in today's NHS | The King's Fund (kingsfund.org.uk)
71. Dunhill L. Health Service Journal 2017. Finance Directors feel bullied by NHS regulators to agree targets. Finance directors 'feel bullied' by NHS regulators to agree targets | News | Health Service Journal (hsj.co.uk)
72. Campbell D 2017 Hospital bosses forced to chant 'we can do this' over A&E targets | NHS | The Guardian
73. Timmins N. The Chief Executive's Tale. Views from the frontline of the NHS. King's Fund 2016 The chief executive's tale | The King's Fund (kingsfund.org.uk)
74. Timmins N. Conversations with NHS Chief Executives, An Insight. King's Fund 2016 Conversations with NHS chief executives: an insight | The King's Fund (kingsfund.org.uk)
75. Chambers N. Exworthy N. University of Manchester and University of Birmingham, Long serving NHS Chief Executives What keeps them going? 2020 Long_serving_NHS_chief_executives_report_final_Feb_2020.pdf (manchester.ac.uk)
76. Oliver D. BMJ 2022. The cultural problems still affecting PPE Provision. David Oliver: The cultural problems still affecting PPE provision | The BMJ
77. Oliver D BMJ 2020. How not to do Covid Comms. Copy our government David Oliver: How not to do covid-19 comms—copy our government | The BMJ
78. NHS Providers Briefing 2024. Culture review of ambulance trusts. otdb_review-of-ambulance-trust-cultures_15-feb-2024.pdf (nhsproviders.org)
79. Moore A. Waiting Times overshadows misconduct, review finds, Health Service Journal 2024 Waiting times focus 'overshadows misconduct', finds NHSE review | News | Health Service Journal (hsj.co.uk)

80. King's Fund. Culture and Leadership in the NHS. 2014 Culture And Leadership In The NHS | The King's Fund (kingsfund.org.uk)
81. NHS Leadership Academy and RCN. Trust. An essential ingredient for collaborative working in the NHS. TRUST-an-essential-ingredient-for-effective-and-inclusive-leadership-in-the-NHS.pdf (leadershipacademy.nhs.uk)
82. David Oliver: Lack of PPE betrays NHS clinical staff | The BMJ 2022
83. HM Stationery Office. Report of the Mid Staffordshire NHS Trust Public Inquiry 2013. Volumes 1, 2 and 3 and executive Summary. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry - GOV.UK (www.gov.uk)
84. The Government's Response to the Francis Report. 2013 Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry - GOV.UK (www.gov.uk)
85. Health and Care Bill. 2022. Policy Paper. Health Services Investigations Body. Health and Care Bill: Health Services Safety Investigations Body - GOV.UK (www.gov.uk)
86. Martin G, Stanford S, Dixon-Woods M. A decade after Francis. Is the NHS safer and more open? BMJ 2023 A decade after Francis: is the NHS safer and more open? | The BMJ
87. Berwick Review into Patient Safety. Department of Health. 2013 Berwick review into patient safety - GOV.UK (www.gov.uk)
88. NHS England. A guide to the Whistleblowers' support scheme. 2021 whistleblowers-support-scheme-guide-update-march-2021.pdf (england.nhs.uk)
89. NHS whistleblowers need to be better protected by the law, says BMA | NHS | The Guardian
90. Time to address whistleblowing concerns across the NHS | Nursing in Practice
91. NHS England. NHS Staff Survey in England 2022. Statistics » NHS Staff Survey in England
92. Health Service Journal Reveals Top Healthcare Employers. HSJ 2014 HSJ reveals the top healthcare employers | News | Health Service Journal
93. General Medical Council, National Training Survey 2023 results. National training surveys - GMC (gmc-uk.org)
94. Gilbert D. Health Service Journal 2023. The Letby Inquiry will not make any difference. The Letby inquiry will not make any difference | Comment | Health Service Journal (hsj.co.uk)
95. Dayan M, Edwards N. "Fact or Fiction. The NHS Has Too Many Managers" Nuffield trust 2015 Fact or Fiction? The NHS has too many managers | Nuffield Trust
96. Commonwealth Fund "Mirror Mirror. Comparing health systems across different countries. 2021 Mirror, Mirror: Comparing Health Systems Across Countries | Commonwealth Fund

97. Kirkpatrick I and Maltby B. “What do NHS managers contribute?” NHS Confederation 2022 What do NHS managers contribute? | NHS Confederation
98. Kirkpatrick I and Maltby B “Is the NHS Overmanaged?” NHS Confederation 2022 Is the NHS overmanaged? | NHS Confederation
99. Kirkpatrick I and Maltby B. “What next for NHS managers” NHS Confederation 2022. What next for NHS management? Messages for Messenger | NHS Confederation
100. Oliver D. Stop wasting taxpayers’ money on management consultancy for the NHS. BMJ 2014 Stop wasting taxpayers’ money on management consultancy for the NHS | The BMJ
101. David Oliver BMJ 2019. Exclusive: Government spending on management consultants trebles in three years | The BMJ
102. Bychawski A. “Management Consultants Raking in up to £3000 a day from the NHS” Open Democracy 2023 NHS paying Deloitte, EY and KPMG consultants up to £3,000 a day | openDemocracy
103. National Audit Office. Overview of the Government’s response to the Covid-19 Pandemic. 2020 Covid-19 Overview - National Audit Office (NAO) Report
104. The impact of management consultants on public service efficiency in: Policy & Politics Volume 47 Issue 1 (2019) (bristoluniversitypressdigital.com)
105. Sturdy and Kirkpatrick. Why the silence on poor rates of return from consultancy spend? Health Service Journal 2018 Why the silence on the poor rate of return from NHS consultancy spend? | Comment | Health Service Journal (hsj.co.uk)
106. Black S. Mythbuster. “The NHS has a management not a funding problem”. HSJ 2024 The mythbuster: The NHS has a management, not a funding, problem | Daily Insight | Health Service Journal (hsj.co.uk)
107. “Managers value you; do you know enough to value them?” by Emma Challans-Rasool and Charlotte Williams – The official blog of BMJ Leader
108. NHS England. The NHS Graduate Management Training Scheme Graduate Management Training Scheme (graduates.nhs.uk)
109. Health Foundation. The Q Community. Together to improve health and care. Q Community | The Health Foundation
110. National Quality Improvement Network National Quality Improvement (incl. Clinical Audit) Network (N-QI-CAN) – A professional network for improving patient care through clinical audit and other quality improvement processes (nqican.org.uk)
111. Advancing Quality Alliance. About us Home - Aqua
112. NHS Leadership Academy. NHS England. About Us About us – Leadership Academy
113. About us | Faculty of Medical Leadership and Management (fmlm.ac.uk)

114. General Medical Council. Guidance on supporting information for revalidation and appraisal, 2021 Guidance on supporting information for appraisal and revalidation (gmc-uk.org)
115. Rose S. Better Leadership for Tomorrow. NHS Leadership Review Better leadership for tomorrow: NHS leadership review - GOV.UK (www.gov.uk) 2015
116. Kark review of the fit and proper persons test - GOV.UK (www.gov.uk) 2019
117. Health Foundation. Strengthening NHS Management and Leadership. Priorities for reform. 2022 . Strengthening NHS management and leadership - The Health Foundation
118. NHS Confederation 2022. The Messenger Review of NHS Leadership. What you need to know The Messenger Review of NHS leadership | NHS Confederation
119. Reforming management and leadership in the NHS: Does the Messenger review go far enough? - The Health Foundation. 2022. Reforming management and leadership in the NHS: Does the Messenger review go far enough? - The Health Foundation
120. NHS chief calls urgent meeting over powers to disbar hospitals managers after Lucy Letby case (inews.co.uk)
121. NHS England. Letter to NHS Executives. Following the Verdict of the Lucy Letby Trial, 2023 PRN00719-letter-verdict-in-the-trial-of-lucy-letby.pdf (england.nhs.uk)
122. Home - Patient Safety Commissioner
123. The Seven Principles of Public Life (The Nolan Principles) 1995. The Seven Principles of Public Life - GOV.UK (www.gov.uk)
124. PSA statement | Responding to calls for regulation of NHS managers (professionalstandards.org.uk)
125. Labour vows to make NHS managers accountable after Lucy Letby failings | NHS | The Guardian
126. Senedd discuss tightening regulation of NHS managers in Wales - Herald.Wales 2024
127. Majority of NHS managers back professional regulation - survey | News | Health Service Journal (hsj.co.uk)
128. Managers fear 'unfair' professional regulation | News | Health Service Journal (hsj.co.uk)
129. Regulating hospital managers is not the silver bullet to a safer NHS (newstatesman.com)
130. The Ward Round: Regulation of managers is the easy answer | Expert Briefing | Health Service Journal (hsj.co.uk)
131. David Oliver Health Service Journal 2023 As a doctor I don't believe regulation of managers should be a priority | Comment | Health Service Journal (hsj.co.uk)
131.CQC The Five Key Questions we ask. The five key questions we ask - Care Quality Commission (cqc.org.uk)

132. The Countess of Chester Hospital NewApproachComprehensive Report (Acutes Location Jun 2016)_SPL1-2532984731 (cqc.org.uk)
133. Safe Staffing Levels for Children's Nursing Benchmarked by RCN 2013. Safe staffing levels for children's nursing benchmarked by RCN | Nursing Times
134. British Association of Perinatal Medicine (BAPM) 2018. Optimal Arragements for local neonatal units and special care units in the UK 2018. Optimal arrangements for Local Neonatal Units and Special Care Units in the UK (2018) | British Association of Perinatal Medicine (bapm.org)
135. CQC Inspection Countess of Chester Hospital 2018. Provider section - RJR Countess of Chester Hospital NHS Foundation Trust (13/11/2018) INS2-4678394720 (cqc.org.uk)
136. NHS England » Code of governance for NHS provider trusts 2022
137. Oliver D. The emptiness of the Clinicians Good, Managers Bad Narrative, Health Service Journal 2023. The emptiness of the 'managers bad, clinicians good' narrative | Comment | Health Service Journal (hsj.co.uk)
138. Oliver D. Why aren't more doctors chief executives? BMJ 2019 David Oliver: Why aren't more doctors NHS chief executives? | The BMJ
139. Hospital boss claims unfair dismissal after chairman 'bullied' her - BBC News
140. Kirkpatrick, I., Altanler, A. and Veronesi, G. (2021) 'Hybrid professional managers in healthcare: an expanding or thwarted occupational interest?' Public Management Review – online ready
141. NHS Providers 2017. Clinician to Chief Executive. Supporting the leaders of tomorrow. clinician-to-chief-executive-supporting-the-leaders-of-tromorrow_web.pdf (nhsproviders.org)
142. Goodall A. The Power of Credible Expert Leaders. Basic Books. London. 2023
143. Baker, Goodall. "Do expert clinicians make the best managers? Evidence from hospitals in Denmark, Australia and Switzerland. BMJ Leader 2021. Do expert clinicians make the best managers? Evidence from hospitals in Denmark, Australia and Switzerland (amandagoodall.com)
144. Gordon C. How to design and deliver a clinical led organisation. Health Service Journal 2012 How to design and deliver a clinically led organisation | HSJ Knowledge | Health Service Journal
145. Bohmer R. Leadership with a Small I. BMJ 2010 Leadership with a small "I" | The BMJ
146. Simonet D. The New Public Management Theory in the British Healthcare System. A Critical Review. Administration and Society 2013 The New Public Management Theory in the British Health Care System: A Critical Review - Daniel Simonet, 2015 (sagepub.com)
147. The Future of NHS Leadership: unpicking Griffiths' complex legacy | HSJ Knowledge | Health Service Journal

148. Health Foundation. Policy Navigator. Griffiths Report on Management in the NHS Griffiths report on management in the NHS | Policy Navigator (health.org.uk)
149. Dunhill L. Health Service Journal 2023. Revealed. How trust execs resisted concerns over Letby Revealed: How trust execs resisted concerns over Letby | News | Health Service Journal (hsj.co.uk)
150. Halliday J. Doctors were forced to apologise for raising alarm over Lucy Letby and Baby Deaths. Guardian 2023 Doctors were forced to apologise for raising alarm over Lucy Letby and baby deaths | Lucy Letby | The Guardian
151. Lucy Letby: victims' families treated 'appallingly', says former hospital boss | Lucy Letby | The Guardian
152. General Medical Council "Good Medical Practice" Updated January 2024 Good medical practice - professional standards - GMC (gmc-uk.org)
153. Nursing and Midwifery Council Code.. Updated 2023 The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates - The Nursing and Midwifery Council (nmc.org.uk)
154. Nursing and Midwifery Council and General Medical Council Joint Guidance. The Professional Duty of Candour Read the professional duty of candour - The Nursing and Midwifery Council (nmc.org.uk)
155. Joint statement from chief executives of statutory regulators of healthcare professionals on the professional duty of candour.
https://www.pharmacyregulation.org/sites/default/files/joint_statement_on_the_professional_duty_of_candour.pdf
156. Oliver D. Should NHS doctors work in unsafe conditions? BMJ 2018 David Oliver: Should NHS doctors work in unsafe conditions? | The BMJ
157. GMC Guidance on doctors working in unsafe rotas. GMC issues advice on safe rotas for junior doctors | The BMJ
158. BMJ. The Bawa Garba Case. Collection of Articles. The Bawa-Garba case | The BMJ
159. Simon Stevens Speech to NHS Providers Conference 2017 in Campbell D. Guardian 2017 NHS waiting lists could soar to 5 million. NHS waiting list could soar to 5m without urgent cash, chief warns | NHS | The Guardian
160. Care Quality Commission. Regulation 20. Duty of Candour. Updated 2022 Regulation 20: Duty of candour - Care Quality Commission (cqc.org.uk)
161. "Fiirst do no Harm" The Independent Review of the Medicines and Medical Devices Safety Review. Cumberlege. 2020 Independent Medicines and Medical Devices Safety Review report - GOV.UK (www.gov.uk)

162. Townsend E. Duty of Candour a “tick box exercise” for overworked leaders, says watchdog. Health Service Journal 2024 Duty of candour a ‘tick box exercise’ for overworked leaders, says watchdog | News | Health Service Journal (hsj.co.uk)
163. Hughes H. Health Service Journal 2023. Government and NHSE need to start listening to patients Government and NHSE need to start listening to patients | Comment | Health Service Journal (hsj.co.uk)
164. Townsend E. NHS Reluctance to be open with families after care failures sparks review. HSJ 2023 NHS reluctance to be open with patients after care failures sparks government review | News | Health Service Journal (hsj.co.uk)
165. The right hon Maria Caufield MP. Commons Written Statement. Review of the duty of candour in health and care settings 2023. Written statements - Written questions, answers and statements - UK Parliament
166. Robert Francis KC. Freedom to speak up. An independent Inquiry into creating and open and honest reporting culture in the NHS. 2015 The Report (freedomtospeakup.org.uk)
167. The Rt Hon Jeremy Hunt MP. Oral Statement to Parliament. Francis Report. Update and Response 2015 Francis Report: update and response - GOV.UK (www.gov.uk)
168. Welcome to the National Guardian’s Office(website). The National Guardian's Office - Freedom to Speak Up
169. Hughes H. Freedom to Speak Up. The Role of the National Guardian’s Office and Freedom to Speak up Guardians. *Future Healthcare Journal* 2019. Freedom to speak up – the role of freedom to speak up guardians and the National Guardian’s Office in England - PMC (nih.gov)
170. National Guardian’s Office Annual Report laid before parliament. 2022-2023. National Guardian's Office Annual Report laid before Parliament - National Guardian's Office
171. Hughes H. Understanding the impact of Freedom to Speak Up. Health Service Journal 2020 Understanding the impact of Freedom to Speak Up | HSJ Interactive | Health Service Journal
172. Jones, Maben et al *Health and Social Care Delivery Research* Volume: 10, Issue: 23, Published in August 2022Implementation of 'Freedom to Speak Up Guardians' in NHS acute and mental health trusts in England: the FTSUG mixed-methods study (nihr.ac.uk)
173. Listening to the silence: What does the NHS staff survey tell us about Freedom to Speak Up? | HSJ Partners | Health Service Journal 2021
174. David Oliver: Lack of PPE betrays NHS clinical staff | The BMJ 2021
175. David Oliver: The cultural problems still affecting PPE provision | The BMJ 2021
176. Covid-19: NHS trusts deny restricting PPE during pandemic | The BMJ

177. Royal College Emergency Medicine 2023. Excess deaths associated with overcrowding and corridor care. Excess_deaths_associated_with_crowding_and_corridor_care.pdf (rcem.ac.uk)
178. Oliver D. Can NHS England's plan for urgent and acute care deliver? BMJ 2023 David Oliver: Can NHS England's recovery plan for urgent and acute care deliver? | The BMJ
179. NHS England Patient Safety Incidents Framework. 2022 NHS England » Patient Safety Incident Response Framework and supporting guidance
180. World Health Organisation Global Patient Safety Action Plan 2021-2030 Global Patient Safety Action Plan 2021-2030 (who.int)
181. Berwick review into patient safety. 2013 Berwick review into patient safety - GOV.UK (www.gov.uk)
182. Smith J. Journal of Medical Ethics 2015. The Francis Inquiry. From diagnosis to treatment. The Francis Inquiry: from diagnosis to treatment | Journal of Medical Ethics (bmj.com)
183. Department of Health. Patients First and Foremost. The initial government response to the report of the Inquiry into Mid Staffordshire NHS Trust. 2013 Patients First and Foremost: The Initial Government Response to the Report of The Mid Staffordshire NHS Foundation Trust Public Inquiry (publishing.service.gov.uk)
184. NHS England. Just Culture Guide. NHS England » A just culture guide
185. NHS England. The Patient Safety Strategy NHS England » The NHS Patient Safety Strategy
186. National Health Executive. 2022. Dr Henrietta Hughes appointed as the first ever patient safety commissioner. Dr Henrietta Hughes appointed as first ever Patient Safety Commissioner | UK Healthcare News (nationalhealthexecutive.com)
187. Henrietta Hughes. Patient Safety Commissioner: 'We are heading straight back to Mid Staffs' | Comment | Health Service Journal (hsj.co.uk)
188. Patient Safety Commissioner. The Hughes Report 2023 The Hughes Report: Options for redress for those harmed by valproate and pelvic mesh (patientsafetycommissioner.org.uk)
189. The NHS England Healthcare Safety Investigation Branch. Directions,. 2022 The NHS England (Healthcare Safety Investigation Branch) Directions 2022 - GOV.UK (www.gov.uk)
190. The Health Quality Improvement Partnership (HQIP). About us. HQIP – Healthcare Quality Improvement Partnership
191. National Institute for Healthcare Clinical Excellence. NICE. Find Guidance Find guidance | NICE
192. NHS England. Getting it Right First Time (GIRFT) Getting It Right First Time - GIRFT

193. NHS Resolution. Clinical Negligence Schemes. The 7 schemes Clinical schemes - NHS Resolution
194. NHS England “Learning from Deaths in the NHS” NHS England » Learning from deaths in the NHS
195. NHS England, National Quality Board guidance on learning from deaths. NHS England » National Guidance on Learning from Deaths
196. NHS England the National Medical Examiner System NHS England » The national medical examiner system
197. Coroners and Justice Act 2009. Coroners and Justice Act 2009 (legislation.gov.uk)
198. Chief Coroners Office. The Notification of Deaths Regulations, 2019 The Notification of Deaths Regulations 2019 (legislation.gov.uk)
199. Chief Coroners Office. Guidance: Notifications of deaths regulations. 2019 Notification of Deaths Regulations 2019 guidance - GOV.UK (www.gov.uk)
200. NHS England SITREP. Neonatal and Paediatric Intensive Care. Statistics » Bed Availability and Occupancy (england.nhs.uk)
201. NHS England Neonatal Critical Care Transformation. NHS commissioning » E08. Neonatal critical care (england.nhs.uk)
202. King’s Fund. Critical Care Services in the NHS. Critical Care Services In The English NHS | The King's Fund (kingsfund.org.uk)
203. Nuffield Trust 2023 Are there enough intensive care beds available for children this winter? | Nuffield Trust
204. HQIP. Natiojnal Neonatal Audit Programme. RCPCH National Neonatal Audit Programme (NNAP) – HQIP
205. HQIP . MMBRACE audit. MBRRACE-UK: Perinatal Mortality Surveillance – HQIP
206. GMC State of Medical Education and Practice in the UK The state of medical education and practice in the UK - GMC (gmc-uk.org)
207. NHS England Update from the Maternity and Neonatal Programme NHS England » Update from the Maternity and Neonatal Programme
208. Statutory Guidance. Working together to safeguard children. Working together to safeguard children - GOV.UK (www.gov.uk)
209. *Alandagady and Chisholm* in *Infant Journal When should a neonatal death be referred to the coroner 2021*
210. Oliver D. The NHS Staff Survey 2023 has depressing and worrying findings, BMJ 2024 David Oliver: The NHS staff survey 2023 has depressing findings and worrying implications | The BMJ

211. Dunhill L Health Service Journal March 2024. "Trust CEOS told to hit A&E targets or risk funding cuts" CEOs told 'hit A&E target this month or risk funding cuts' | News | Health Service Journal (hsj.co.uk)
212. NHS England Board 2022 Paper Julian Kelly on "NHS Financial Performance Update" 221201-item-4.2-financial-performance-update.pdf (england.nhs.uk)
213. NHS England Revised Fit and Proper Persons Test for Board Directors. August 2023 at NHS England » NHS England fit and proper person test framework for board members

311. Written Evidence

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Statement of Truth

I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true. The opinions I have expressed represent my true and complete professional opinions on the matters to which they refer. I understand that proceedings for contempt of court 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 in its truth

Signed: ____Professor David Oliver MD, FRCP_____

Dated: ___11/6/2024_____