HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: NHS Leadership, Performance and Patient Safety, HC 521

Tuesday 16 April 2024

Ordered by the House of Commons to be published on 16 April 2024.

Watch the meeting

Members present: Steve Brine (Chair); Paul Blomfield; Paul Bristow; Mrs Paulette Hamilton; Dr Caroline Johnson; Rachael Maskell.

Questions 1 - 55

Witnesses

I: General Sir Gordon Messenger, Leader of the review of NHS leadership for a collaborative and inclusive future; and Professor Rich Withnall, Chief Executive, Faculty of Medical Management and Leadership.

II: Matthew Taylor, Chief Executive, NHS Federation; and Rebecca Hilsenrath, Chief Executive, PHSO (and Acting Parliamentary and Health Service Ombudsman).

Written evidence from witnesses:

– [Add names of witnesses and hyperlink to submissions]

Examination of witnesses

Witnesses: General Sir Gordon Messenger and Professor Withnall gave evidence.

Q1 **Chair:** Good morning. This is the Health and Social Care Select Committee, back after Parliament's Easter recess. We are in the Grimond Room in Portcullis House in Westminster. We are a cross-party Committee of MPs who scrutinise the work of the Department and various other arm's length bodies, holding various inquiries, as people know. We are starting a new one today which is called NHS leadership, performance and patient safety.

This is the first oral evidence session of the inquiry. Very briefly, we are interested in the relationship between the NHS and patient safety. We are looking at how good leadership differs at the different levels. There are, of course, trusts, which is what patients would most interface with alongside their primary care providers. There are integrated care boards—ICBs—and primary care networks. There are so many different levels of the NHS in England, all of which have leadership to varying different degrees. We are interested in all of that.

We are interested in looking at the recommendations of various Government-commissioned reviews over the years, including Kark in 2019 and Messenger in 2022. That brings us on to who we have before us today in our first panel. We have the aforementioned Messenger: General Sir Gordon Messenger, to put it in its fullest term. He is the leader of the review of leadership for a collaborative and inclusive future that was carried out for the Government two years ago. We also have Professor Rich Withnall, who is the chief executive of the Faculty of Medical Leadership and Management.

Thank you very much, gentlemen, for giving evidence to us at the very start of this inquiry. General Messenger, two-plus years on from your work, how do you reflect on it now and how do you think it has changed—if indeed it has—the thinking around leadership in the NHS?

General Sir Gordon Messenger: I and the team around me commenced the review at a time when there was already an understanding in the national health service that the workforce needed investment and needed to be treated as a fragile resource in order to get the best from it. Of course, the work that was done to produce things like the people plan and many other initiatives that came from that were a symptom of that. What we have seen since the review was published is a conscious effort to tackle some of the recommendations that the review made. I think that is positive and ongoing.

If I had to point to the other side of the ledger, I would say that a great deal of the review centred on developing the right cultures and behaviours across the organisation. I would summarise those as, first, having collaboration and teamwork as the central ethos of the workforce and, secondly, viewing leadership not just as those with the word in the title but the leadership required at every level, from the very top of NHS

England down to the workplace. Everyone should feel a leader and a team member. Of course, that cultural shift will not happen in a year, or two or three years. It happens through consistent application of measures to try to seek those cultural improvements.

Q2 **Chair:** Thank you. To go a bit further back, when you were asked to do that, what was the exam question? What was the problem that Ministers at the time were seeking to answer?

General Sir Gordon Messenger: It was twofold, and they are the two key questions. How can we improve patient safety and how can we improve productivity? Are there ways in which we can improve the leadership and management—there is a difference—of the national health service to improve both patient safety and productivity? That was the exam question.

Q3 **Chair:** You called for leaders to prioritise patient needs over the needs of the hierarchy. You said looking out, not up. In a nutshell, what prevents leaders from doing that? Is it culture? Is it personnel?

General Sir Gordon Messenger: Others are more expert on this than I, but I would note that during the review we saw a great deal of people focused on meeting stipulations, standards and targets. They invested a huge amount of effort on delivering against often centrally imposed and sometimes politically imposed targets. That was almost always to the detriment of time spent with patients.

Q4 **Chair:** It is fascinating to have you both here. I will bring in Professor Rich Withnall. General Messenger, you were vice-chief of the defence staff and a Royal Marine. Rich, you are director of defence healthcare at the UK Ministry of Defence. You have both come from that world into this world. Is the NHS well led at the moment, Professor Withnall?

Professor Withnall: First, may I thank you and the Committee? For context, the Faculty of Medical Leadership and Management was established in 2011 by all the medical royal colleges and we are endorsed by the academy as a means of developing leadership. That flowed from lessons learned after strategic shocks like Bristol Royal Infirmary and Mid Staffs. I think we would all agree that the tragic recent events at the Countess of Chester suggest that there is still quite a lot of work to do.

We are a values-based charity with a professional home for medical leadership in the UK. Our objective is to raise the standards of patient care by improving leadership, because effective leadership saves lives. This is the first time we have been invited to the Select Committee, so thank you very much indeed for that opportunity, as we continue to face intense pressures and the FMLM continues its developmental journey to the Privy Council to become the UK college of clinical leadership.

To your question, Chair, there is a huge amount of pressure within the system, which constrains leaders' abilities to protect patient safety at the moment. We all recognise that the NHS has many hierarchies, but I don't

think the organisational structures themselves should be the end. Kates and Galbraith, as far back as 2007, said that organisations are just vehicles to achieve strategic aims. It is not about what the organisation looks like; it is about what they are trying to achieve. We absolutely agree with General Messenger. We think that the NHS quadruple aims are appropriate and laudable, but the challenges are probably broad and deep.

To start with demand, we have 6.3 million patients waiting for 7.5 million treatments at the moment. We have 75,000 patients waiting more than 65 weeks. As we have seen in the last 24 hours, the number of children waiting up to a year for treatment has gone up nearly 10,000 since last April and 85% since January 2023.

We also need to look at society. It is a triumph for medicine and public health that people are living longer, but that comes with more concurrent diseases. We are better at diagnosing things like cancer, ADHD and mental health, so leaders need more capacity to be able to treat the extra patients, despite, of course, the increasing fiscal challenge. From our perspective, the coming year looks very challenging financially. There is less than 0.5% growth in spending in real terms, whereas most health economists would advocate spending growth of about 3.5% to keep up with demand.

It is difficult for leaders to increase productivity when we have failing infrastructure and outdated equipment. Our capital investments have lagged behind OECD for decades. The UK's healthcare productivity has only averaged a mere 0.9% over the last 25 years. Of course, we have staff shortages and poor morale.

We should recognise and celebrate the progress, though. The fact that waiting lists have fallen for the fifth month in a row is good, but the waiting list of 7.54 million is still more than 300,000 from when the Prime Minister announced pledges to reduce waiting.

Q5 **Chair:** Are you saying that we have good leadership in a poor context, where capital spend is desperately needed? The two have to work hand in hand. You can be the best leader in the world, but in poor infrastructure and with a poor workforce you are going to struggle. To give it a football analogy, you can be Pep Guardiola but if you are managing Spurs—my team—God help you.

Professor Withnall: I think that is right. I am sure that Matthew from Confed will want to make the point again that you can have the best leaders in the world, but when you are trying to run a system that is 100,000 people short it is a real challenge. You've got to have an A team to put on the pitch, to follow up on your football analogy.

The other thing that we ought to bear in mind is that we have recurrently changed our structures to try to solve the problem. I am not sure that that really gets to the heart of it. It is right to bring NHS organisations,

local authorities and others together to take collective responsibility, so I am in favour of ICSs. They have been around in some form or another since 2016. Actually, those leaders—your Pep Guardiola analogy—are operating without a guidebook. There is variation across leadership because of the challenges that we have outlined. Leaders are trying to do really good work but are building on quicksand at the moment. What we need is consistent, realistic and long-term funding.

Q6 **Chair:** I explained the context of your former professional lives. You were always, obviously, expecting good leadership in the armed forces. They also have challenges around infrastructure, numbers, supplies and kit, but we still need good leadership to happen. It would be unfair to ask for one thing, so what would be your top three things from your former world into this world that would move the dial?

General Sir Gordon Messenger: First, the sense of pride and belonging in the organisation that I was part of. I served 36 years in the Royal Marines. It took five weeks for me to culturally feel like a Royal Marine and understand the Royal Marines' culture and be proud of it for the rest of my career. I don't think that that entry point in the health sector is utilised enough to drive a sense of cultural belonging and pride in what they do.

Equally, I always felt very well managed by the system in terms of career. Sometimes that was great news because I was asked to do things that I wanted to do, but sometimes I was asked to do things that I would not have chosen to do but were considered to be in the best interests of the system as a whole. I did them, and I was either rewarded or otherwise for that.

The workforce, above a certain level, needs to be seen as a cross-organisational asset, obviously within tolerances of a very different workforce in the health sector than in the military. That can be veered and hauled to tackle the challenges that are considered the higher priority, in order to put the right skills in the right place to give the best chance of success.

Q7 **Chair:** Interesting. Professor Withnall, if you had to put a couple of things from your old life into the context that we are interested in, where would you land?

Professor Withnall: My points, Chair, would be through-career leadership development. Leadership does not happen by mistake in the military. I think, for example, we need to start on day one of vocational training for clinical people and for non-medical managers. I think that helps us mitigate current risks of accidental leadership.

The second point that I would suggest is ring-fencing central moneys to fund leadership training and developmental bundles. That inspires, nurtures and grows leadership talent, so that you have a pathway of people you can pull through the system. The military does that very well.

Chair: What a start to our inquiry. Excellent. Over to Rachael Maskell.

Q8 **Rachael Maskell:** Thank you ever so much and thank you both for joining us today. I want to reflect a little bit. Since 2010, we have had 15 different inquiries. Some are ongoing at the moment. All were highlighting broadly similar challenges within the system. However, it feels like we have done a diagnosis, but we do not know the treatment. Why haven't we seen implementation coming through over all of this time, particularly thinking back to the work of Robert Francis and right through to today, to bring about the cultural change necessary to ensure patient safety?

General Sir Gordon Messenger: First, you are right to highlight a number of overlaps between them. It is important that those overlaps are taken into account and the implementation challenge is viewed across the totality of the conclusions that the various reviews have made.

The answer is that it is really hard to drive cultural change in a hugely complex and non-unitary organisation such as NHSE. Sometimes the complexities and the fear of what I would call second-order effects—that is, I do something in this part of the system and it's going to have a detrimental effect in that part of the system—creates a stasis. Specifically on the issue of driving the right cultures, you have to start somewhere. Sometimes that looks quite small and insignificant, but it can have a big impact.

One of the challenges about driving cultural change is that it is very hard to quantify. You can make investments designed around cultural and behavioural change, and invest in people and leadership, but the outputs of that investment are very rarely quantifiable in the clearcut way that happens in other parts of the system, when you are building a new hospital or buying a new piece of equipment. You are never going to get beyond that. You just have to accept what I think is absolute common sense. If you have a workforce that is well led, well motivated, resilient, inclusive, cares about what it does, self-polices, self-motivates and tackles things through a collective and collaborative approach, you are going to get better patient safety and better productivity. Taking the punt and investing in those things, hard though it is, would be my comment on how to move this forward.

Q9 **Rachael Maskell:** Thank you. May I turn to Professor Withnall?

Professor Withnall: I completely support and endorse General Gordon's philosophy of the right leadership being in place at the right levels. I think that is what it is about, but I don't think we are there yet. That is one of the challenges as to why we need to continue to build on the review. The recommendations for practical structures and consistency in leadership are key.

There is a risk that we still face an inverse care law because the leadership standards are different in different places, and the competence and confidence of leaders is also different in different places. We could do

more to promote collaborative behaviours. That is something that we have seen in previous reviews. We have touched on it briefly with ICSs, but there is more work to be done there. I certainly think that, as the review says, we need to recognise and do more to promote equality, diversity and inclusion in our leadership roles. We have a long way to go there.

Finally, it is about incentivising leaders to be competent and confident and want to take on really challenging roles. If the General will forgive me, his review is one in a long line of reports. Your own expert panel's evaluation last month was that, actually, the Government still require improvement in implementing all of these patient safety things. The reviews and the reports are important, but what we need now is action.

There are maybe two other things that I didn't mention in answer to the Chair's point. It is around maintaining clear boundaries between formative leadership developmental support and statutory regulation. You need to grow people in order to give them competence and confidence. It is constraining if that is linked too closely with regulatory business. There are lots of good recommendations in all of the reports, but we now need to do a thematic analysis, drag them all together and invest in some of those developmental actions.

Q10 **Rachael Maskell:** We have a very heavily managed NHS. There is no doubt about that. You are very much talking about leadership. How do we get an understanding of the differential between management and leadership, and see the primacy of leadership in driving cultural change in the NHS?

Professor Withnall: If I may, I would like to suggest that this is a team sport. Clinical leaders and non-medical managers need to work really closely together. If we go back to the Kark review in 2019, there were some really helpful recommendations there around the "fit and proper person" test. With respect, we have to resist the temptation perhaps to misrepresent the Kark report and, to an extent, General Gordon's review. There have been attacks on NHS leaders and a bit of a culture of manager-bashing has stepped in. I don't think we are overmanaged in the NHS. We don't actually know the number of people operating in roles that feature leadership. We need to do research and understand that better.

What we know is that managers make up only 2% of the NHS workforce. If we look in other sectors, it is about 9.5%. It is about having competent and confident managers to support the team sport. We need to fully appreciate the top-down pressures that demands are putting on leaders and managers. Back in 2005, Caine coined the term "goal odyssey", where goal setting and pursuit can lead to unintended consequences. I think we are facing that today, all of these years on. I am sorry to keep returning to it, but the evidence suggests that all high-performing healthcare systems need investment in effective management. We need to do more to support our NHS managers and our clinical leaders through

a regulatory framework to strengthen accountability because that enhances patient safety. We need to challenge the narrative that we have too many managers in the NHS, and stop manager-bashing.

Q11 **Rachael Maskell:** That is a really interesting response because, in your previous responses, you were talking about leadership rather than management. I am trying to differentiate the two. General Messenger?

General Sir Gordon Messenger: There is not a single manager in the NHS who is not also a leader. The manager is what they do, and leadership is how they do it. I think it is really unhelpful to differentiate leaders and managers because that is just not the reality.

Q12 **Rachael Maskell:** I think they are different qualities in being able to drive forward change. That is what I am trying to draw out. A management system is clearly about managing change as opposed to providing the draw-up for that leadership.

General Sir Gordon Messenger: As I say, I think that every manager has to demonstrate leadership and is a leader in the system.

Q13 **Rachael Maskell:** Can I touch on ICBs? Obviously, they are new in the system. They have had significant budget cuts already and they have been given the impossible task of drawing together different parts of the system, primary and secondary care as well as social care, and working with third-sector organisations as well. How do we ensure that the culture is set right in the ICB frameworks to be able to bring the system culture to where it needs to be, to keep patients safe, setting the priorities and also ensuring that the system is working as one?

General Sir Gordon Messenger: I am not the expert on ICBs, but I can make a couple of comments based on my experience with the review. At the heart of this is establishing a natural awareness of what goes on beyond the particular sector or organisation that one is in, encouraging a culture of collaboration and not viewing one's own outputs as the only important ones but recognising that if you want good patient outcomes you need to be able to work and understand the realities of others.

One of the routes towards that is greater fluidity in the workforce between sectors and between organisations and trusts, so that people are not brought up simply in a particular part of the system and have no real skills or awareness beyond that system. They should understand the realities of primary care, the ambulance trust world and local government. I would argue that there is insufficient fluidity of workforce that allows those that come to the ICBs to feel part of a community that they have lived their career through.

Q14 **Mrs Hamilton:** Good morning, both. My question will drill down a little bit. I have read the Kark review. In that review, which was published in 2019—February, if I remember rightly—there were seven recommendations. The Department of Health accepted five of them, but two of the recommendations weren't accepted.

I want to talk about just one of the recommendations. The Department of Health and Social Care rejected two recommendations, but the one I want to talk about is the power to disbar directors for serious misconduct. I know that it has been revisited, but I would like to ask you, Professor Rich Withnall, what your views are on that.

Professor Withnall: Thank you very much indeed. We need to understand public opinion in answering that question. Members of the public are still deeply committed to the NHS's founding principles, but I think they have lost confidence in the NHS at the moment. We saw in the British social attitudes survey that public satisfaction has fallen to the lowest since records began in 1983.

Of course, patient satisfaction and safety is about more than just the regulation of managers, but the Kark review is relevant in this context because it primarily looked at preventing unsuitable staff from being redeployed or re-employed in health and social care settings. Under the "fit and proper person" test, if directors are found to be wanting in some of those areas, it is important for patient safety that actions are taken. I believe what Kark was saying is that there is a duty on us to develop competencies for directors. There is a need to have, for example, a central database of directors' qualifications, training and appraisals. We need to expand the definition of what serious misconduct is. Without doing those things, there is a risk of sanction overtaking what Kark was actually trying to espouse in those seven recommendations.

To repeat a point I made, we need to avoid the temptation to misrepresent the Kark report as a justification for manager-bashing but, to ensure patient safety, if colleagues are found to be incompetent in their roles or themselves or are under-confident and not wanting those responsibilities, then I believe that sanction is appropriate.

Q15 **Mrs Hamilton:** When I read this, my first view was that in any other profession you would automatically be barred if you did something that led to the death of others. I understand that you say things need to be put in place, but I am struggling with the fact that this sanction is being resisted. We see quite a lot of directors who just move from place to place. They get it wrong in one place and they drift into another job because they know how to answer the questions. Do we not need to have some clear sanctions so that they have markers?

Professor Withnall: I think we do, but I would politely suggest that those sanctions need to be against an appropriate regulatory framework that sits with accountability and is underpinned by patient safety. I am not for a moment suggesting that people who are not diligently discharging their responsibilities, and are therefore culpable in some proven way, should not have sanction. What I am saying is that we need to recognise that clinical tragedies are often multifactorial, with lots of different influences behind them. I think it is overly simplistic just to blame a particular manager and apply sanction at that level without looking at the wider context and the wider system.

Q16 **Mrs Hamilton:** Fair enough. I will widen it, but still on the same theme. My second question is this. I know that the Kark review is not your particular review, but I am sure you have some awareness of it. Is the way it has been introduced and implemented developing a fear culture among NHS leaders that will reduce openness to report issues, problems or any errors that are made?

General Sir Gordon Messenger: I am not well qualified to talk about Kark, but you are right that I am aware of it. I would broaden it a little, if I may, to the point about people feeling reluctant, nervous or wary of highlighting problems that they know exist and can see exist, but in doing so might raise their profile in the system. They may be pushing their head above the parapet, if you like, when it comes to apportionment of responsibility for that.

It is a real shame that that is the natural inclination of many. Of course, that is not the case everywhere, but it certainly exists as an instinct. I feel that it is a symptom of people not feeling supported, not feeling collectively responsible and sometimes too alone, so that they feel that if they are the ones who highlight a challenge, the onus is on them and the spotlight falls on them. I would argue that the best human reaction that one wants in the workplace, when one sees something that is not right, is to rally around those on the same team as you and work out how you can overcome it, eradicate it and move beyond it. Too often people feel that it is too individual. I think that is a symptom of a lack of teamwork in the workplace.

Q17 **Mrs Hamilton:** That was an excellent answer. Thank you. I am going to ask you to answer the same question, Professor. On the teamwork piece—the piece where people don't feel part of the team—how do you feel we can develop the team and reduce the fear culture that is definitely there in the health service?

Professor Withnall: I think the sentiments that the General has expressed are there in the evidence. The King's Fund reported that a third of NHS providers have at least one board-level position vacant at the moment. It is especially worrying for patient safety when that statistic is true in trusts with poor performance or quality issues and that are in special measures. To remedy that, we need to recognise that the loss of clinical leadership could be delivering multiple second-order effects. It could be strategic instability. It could be wasting financial resources. It could be further reducing morale. There is a big literature on that. Of course it adversely impacts on quality of care.

There are three things that we probably could usefully get after. The first is trying to correct the perceived blame culture in the NHS. I completely agree with General Gordon. Executives feel exposed if anything goes wrong, even if those things are completely outside their control. The second thing is that we need to take active steps to reduce excessive regulation. The third thing is that we need to manage unrealistic expectations of what can be achieved in short timeframes. The King's

Fund has written on that. They have concluded that all of those things compound to have a negative impact on staff morale. If you have a negative impact on staff morale, there are second-order consequences for costs and for performance.

Mrs Hamilton: That is an excellent place to stop.

Q18 **Paul Blomfield:** I want to follow up Paulette's theme with you, General Messenger. Among many things, your report talked about the context in which staff were operating. You said it can create a sense of futility and helplessness in the workforce because individuals lack the tools or the ability to rectify what they see going wrong. The Countess of Chester case, which was mentioned, highlighted that. The ombudsman commented on the number of clinicians who had raised concerns but nothing happened.

That still has not gone away. Last year's NHS staff survey reported that only 70% of staff felt safe raising concerns. Only 60% thought that the organisation that they worked in would address concerns seriously if they were raised. We are a long way from where we need to be in creating the culture in which the organisation embraces and welcomes the engagement of staff in raising concerns that your report was seeking to address. I wonder if you could reflect on that and where we need to go now.

General Sir Gordon Messenger: First, the statistics that you outline are a great measure of how an organisation feels at the coalface, what the workplace feels like and what individuals feel like. I don't think they are very attractive statistics in any way. They need to improve. It touches on the point I made earlier about people not feeling naturally part of a team. Again, that is a generalisation. I know that some fabulous teams exist across the board, but too frequently people feel alone.

There were two behaviours that surprised me the most in the review. The first was the blame culture and the finger pointing, in order to offset the focus on you to something or someone else. That can happen. The other was what we described in the report as responsibility avoidance, whereby workers and colleagues were coming into work and delivering absolutely to the letter what they needed to deliver, but without any ostensible interest or engagement in what happened beyond their specific work responsibilities, particularly when it came to collective improvement or organisational betterment.

One of the observations that the review mentions is that that is not restricted to the level of skill in the workforce. Indeed, some of the more highly skilled members of the workforce exhibit similar traits, including senior medical and surgical professionals. That surprised me as someone who had had a military career. I am not for a second suggesting that all cultures in the military are perfect, but issues of responsibility avoidance and blame culture are not often witnessed in the military. There is something about the fact that we naturally gravitate to collective

responses, collective cultures, teamwork and belonging, and to having the ability to rely on those around you, and having the confidence that one can, that I didn't think existed strongly enough or frequently enough in the workplace in the health sector.

This is what I am getting after when I talk about really deep, endemic cultural change. How do you really try to break out of that so that people feel safe and naturally feel more and more responsibility the more senior and more skilled they get, and are ready to lean in when they see things that need to change?

Q19 **Paul Blomfield:** That is very helpful. What the Letby case showed was that there were a lot of people working at the Countess of Chester who wanted to do what you have described. They wanted to raise their concerns. They wanted to be heard when they saw things going wrong, but the system crushed them. In a sense, that is still there in the staff survey numbers from last year. How do you achieve cultural change when the system stops the sort of behaviours that are there?

General Sir Gordon Messenger: I don't know the ins and outs of that, but I know that one has to have a system that is receptive and that listens and acts on the sorts of noises coming out of the workforce that occurred in that particular case.

Q20 **Paul Blomfield:** Can I ask you one further question? It is a system issue. In your report you talked about the pressures that create the organisational instinct to prioritise the needs of the system over patient safety. How far are the metrics imposed on the system creating that sort of behaviour? We all recognise that we need to measure performance. Are we getting the performance measures right? Is there a contradiction between the metrics that we set and the culture that we want? Could we change the metrics to get the right culture?

General Sir Gordon Messenger: That is an important point. It is an important dynamic which extends way beyond simply the completion of the metrics. I think it has an impact on the workplace dynamic that we have both described.

It is not for me to determine which areas of regulation are more important than others. It is not for me to determine which performance measures are more important, but I would argue that if you have an organisation that is overly performance-managed and overly regulated, it becomes a less efficient and less effective organisation. I would certainly commend, and I know that I am not alone, a look at that and a review of the impact it has on behaviours.

Q21 **Paul Blomfield:** Professor Withnall, would you like to comment on any of the points that I have just raised with General Messenger?

Professor Withnall: If I may, Mr Blomfield, I would like to pick up on standards a little bit. Performance standards can be useful. They can help define processes. They can define outcomes. They can help concentrate

the minds of those responsible for a service. Of course, they can justify investment of taxpayers' money.

The other really big point in terms of patient safety is the need for us to think more about professional or personal performance standards as well. I agree with the Hewitt review. I am pleased that the national NHS planning guidance has reduced from 133 targets in 2022-23 to 31 in 2023-24, but of course Hewitt urged a reduction to 10 national targets and for ICSs to set their own priorities.

I think we should invest more in our people. It is support for personal standards that we need, and I am not sure that we are doing quite enough there. We need comprehensive, strategic developmental standards set by a professional body. We need mechanisms to support leaders' professional development and create psychologically safe spaces for people to raise concerns when they have them. It is important that we support the welfare of our leaders. They are doing a really difficult job in very challenging circumstances.

I am delighted that yesterday NHS England extended the NHS practitioner health service. I think that is really important. They have seen 32,000 colleagues since they started 16 years ago. I hope we can shore up long-term support for that particular scheme. Ultimately, I hope that the cross-party support that we have seen for developing FMLM into a college of clinical leadership can become a reality. I think the point of commonality for all of your different threads is the need for a pan-NHS, multidisciplinary professional body to provide guidance and assure evidence-based standards and curricular and guidance frameworks. We need to benchmark clinical leadership against professional standards. We need a membership body that can provide, if you like, a dataset of suitably competent and confident clinical leaders and non-medical managers, which will support recruitment, promotion and retention in NHS leadership roles. If we do that, it puts us on a better footing to support the improvement and the implementations of all the excellent reviews, as your own expert panels felt was required.

Q22 **Chair:** You talked about the role of clinical staff in leadership, so finally from me, I want to draw together your thoughts on that before we move on to our second panel. Would we see improvements in patient outcomes if clinical staff played a greater role in leadership? How do we get from A to B on that, Gordon?

General Sir Gordon Messenger: By investing more in leadership training and development for clinicians. At the moment it is not as institutionalised, arguably, as it could and should be. I would argue that there is insufficient leadership training and development in the initial training of both nurses and medics. The competencies of clinicians as they go through their career are rightly judged against their professional acumen, but they need also to be judged against their leadership acumen and their behavioural approach to the way they do their business.

Q23 **Chair:** You said in recommendation 1 that there should be development of a new national induction programme for NHS and social care staff. In its response to this inquiry, which we will publish today, the Department says that that will be launched in spring 2024. Is that news to you?

General Sir Gordon Messenger: It was. I am delighted. I will be interested to see what the nature of it is. Inductions can be toilets and fire escapes or a cultural and DNA-shifting moment in one's career. I will be very interested in what it contains.

Q24 **Chair:** Are you saying that you have not had sight of that and you have not been involved in that?

General Sir Gordon Messenger: I have not, no.

Q25 **Chair:** Does that surprise you or disappoint you?

General Sir Gordon Messenger: It doesn't. I have been asked by the NHS to support them in some other work, but not specifically that. I don't feel neglected or ignored by them.

Chair: That is a very good approach to take. There is a final question from Paul Bristow, and then we will change panels.

Q26 **Paul Bristow:** General Messenger, I was taken with the comment that you made about it being common sense that if you have a well-led team and a well-led workforce, you will get better productivity and better outcomes. That is, of course, common sense. Why do you think that is a challenge for some in the NHS, not to accept but to embrace and implement?

General Sir Gordon Messenger: I don't think it is just an issue for the NHS. I am not suggesting that they don't have tools at their disposal that they could deploy. It is often the expectations that are placed upon them by external parties, including politics, whereby they are judged, perfectly acceptably, against their efficiency and their patient outcome record. They are not necessarily judged on how happy or valued their workforce is.

I just go back to the point I made earlier about how hard it is to quantify investment in achieving a well-led, well-motivated, resilient and inclusive workforce. I am of the view that one needs to accept that it is really hard to quantify that, but one needs to do it anyway. It needs to be a priority alongside some of the pressing operational challenges, despite the issues of the golden thread through to impact.

Q27 **Paul Bristow:** Would you argue that perhaps some of the targets and metrics you were talking about earlier, as well-intentioned as they are, are making the realisation of that a challenge?

General Sir Gordon Messenger: Yes.

Q28 **Paul Bristow:** The Lansley review stated that it wanted to take the NHS out of politics. How do you solve the tension between the outcome that

you want, giving staff the headspace and the ability to go out and have leadership, and political accountability and transparency? I would argue that in many ways political leadership has led quite often to some of the biggest improvements in healthcare. I am talking about things like hospital-acquired infections. When you have that political focus, it has led to significant patient safety improvements.

General Sir Gordon Messenger: Of course that is true, and of course it is a highly charged and highly relevant political issue. I am not suggesting otherwise. I think the balance needs to be struck. It is not just politics. It is the regulator and other external pressures which have a similar impact. Interventions need to be done collegiately and collectively with the common goal of improvement. I am not convinced that that has always been the case.

Chair: Thank you very much, General Messenger and Professor Withnall. Thank you for giving evidence to us at the start of this inquiry. It was really insightful and helpful.

Examination of witnesses

Witnesses: Matthew Taylor and Rebecca Hilsenrath gave evidence.

Q29 **Chair:** On our next panel we have Matthew Taylor, chief executive of the NHS Confederation, who is well known to this Select Committee and has been before us before. It is nice to see you again, Matthew. We also have Rebecca Hilsenrath, who is chief executive of the Parliamentary and Health Service Ombudsman. Thank you both for being here.

You have heard the evidence given at the start of this inquiry by panel one. Rebecca, in your evidence to us you said that there are some "excellent examples" of NHS leadership, but there "is a long way to go to ensure this…culture is embedded consistently across the NHS." There are good examples of leadership in Government, but whether it is everywhere in Government is another matter. It is always the challenge to see that that happens across Government. First of all, what do you mean when you say that in your evidence, and what needs to happen to ensure that it is embedded consistently across the NHS? I think the key word is "consistently".

Rebecca Hilsenrath: Thank you very much for including me in this session and inviting me today. You are familiar with the work of the ombudsman. We hear complaints about the NHS, and because of that our lens is very much looking at what goes wrong. We are, of course, aware of the many examples of brilliant people across the NHS who are dedicated and do phenomenal things. We are aware of good practice as well as bad practice.

It is important to recognise the enormous pressures on the NHS, recently through the pandemic and other rising levels of demand, but also historically. It is important to recognise that some of the areas of difficulty in the NHS are not actually connected to those recent pressures.

They are endemic to some of the issues that you heard about in the recent session.

On inconsistency, we don't see through our casework many great examples of good practice; otherwise we would not be looking at issues that have been brought to us as complaints. We do, however, see good practice in the work we do with stakeholders. I will give you just one, slightly random, anecdotal example, but it brings me on to quite an important point. I have spoken to an NHS chief executive who regularly meets complainants in relation to his trust. He talks to them about what has happened and understands their perspective, and also what happened in terms of the response they got from the trust. This person employs patient partners, people with lived experience, to oversee responses from the trust to people who have suffered some form of harm. That doesn't happen across the NHS. We are aware that there are areas where there is a very poor response to people who have suffered some sort of harm and that, critically, learning does not result because of that defensiveness. We know that there are areas where they struggle perhaps to ensure the best leadership and the best candidates at senior level.

We would like to see more consistency. We would like to see better structures that enable some of the really brilliant practice to move more consistently across the NHS. From our perspective—I am sure we will work towards this over the session—the focus on working with users on listening to complainants is an absolutely critical way to ensure that your service is user-focused and that you really understand what is going wrong and are using those experiences to improve your service. That is the critical thing that we need to see more consistently across the NHS.

Q30 **Chair:** Matthew, welcome. Is the NHS well led? I know that is a big question because, as I said in the introduction, there are so many different layers to it. Take it generally first. Is it well led? Then zoom in on some parts of it, if you will, as to where you think it is and is not.

Matthew Taylor: I add my thanks for inviting me to the Committee. The NHS Confederation is delighted that the Committee is looking at this issue. You consistently, as a Committee, have demonstrated a capacity to look at issues in the round and to put them in a useful context. It is very important to do that here.

I think the NHS is well led. Any large institution will have a standard distribution of leadership. I think sometimes politicians like to imagine that they can abolish the standard distribution. Some people are outstanding. A lot of people are pretty solid and pretty good, and some people find things difficult. That is always the case. The question is how you deal with that, and enable the leaders who are the most successful to spread their practice and spend time with their colleagues. How do you shift the centre of the curve a little bit to the right, so that you improve the average, and how do you effectively intervene to support people who

are facing challenge and, if necessary, recognise people who are not up to the job? That is what the heart of this is about.

I don't want to repeat the eloquent comments that Rich Withnall made earlier about context, but I encourage Committee members to think about the context because it is material. If you are a leader in the NHS, you are working in the context of a gap between demand and capacity. You are working, for example, in the context of a £11.5 billion maintenance backlog. Many leaders are asking their workers to work in circumstances that are far from satisfactory; indeed, in some cases they are almost dangerous.

You are working in a highly centralised and politicised environment. As you all know, the planning guidance for this year for leaders in the NHS arrived the day before the beginning of the new year. I think most people in the health service, recognising the financial settlement, assume that at some point this year more money will have to be provided, so yet again, we will have a situation where you are given some money at the beginning of the year and then, later in the year, there is a short-term burst of money because it is essential. That is not a great way of doing things.

For reasons that I entirely understand, the Department and NHS England need to say that things are getting better and improving, while at the same time public confidence is at an all-time low. We have a duty of candour in that environment. Where all academic research shows that the NHS is under-managed, on a consistent basis both the media and politicians are prone to do a bit of manager-bashing.

Why does that matter? First, it matters because it is important that the centre models the leadership that it wants to see. That is not a rhetorical point. The centre needs to model the leadership that it wants to see in the rest of the system. One of the things that leads to a certain amount of cynicism is when you see the centre not behaving in the way that those running organisations are expected to behave.

Secondly, and more important, it is vital to take responsibility for the overall ask and expectations that we have of leaders in the health service. We can pour in ever more recommendations, targets and incentives, but it feels to me very rare that anyone stands back and says, "What does this all actually amount to?" The danger is that, as we require more, what we develop is a culture of compliance, and all that boards do is try to make sure that they tick every single box that is put in front of them. In the end, that is not leadership; it is mere compliance in a context that feels very difficult. I hope that you will reflect on that.

The second point to say at the beginning is that it is important that we are talking about patient safety, but I feel that sometimes the debate about patient safety is separated from a broader conversation about risk. You have kindly said in the past that you listen to "The Moral Maze". If I can channel my Moral Maze thoughts, when we talk about patient safety,

we use a kind of Kantian framework, which is to say that patients must always be safe, and it is an absolute imperative. Of course we agree with that; patient safety is a top priority for leaders. But leaders are also utilitarians. They are also people weighing up the different risks that are endemic in a system where you have 7 million people on waiting lists, tens of thousands of people who have to wait too long in accident & emergency departments, and hundreds of thousands of young people who are not getting the mental health intervention they need. Somehow, when we talk about safety, we need to talk about it in the context of risk overall: "What does that take me to, practically?" We need to be clear about risk, and we need to be more open with the public than we sometimes are about risk.

I want to finish by giving you a very concrete example. In the winter before last there was an open conversation about the fact that we needed to manage the risk in the system. That led to a recognition by acute leaders that the biggest risk lay in ambulance response times. That meant that there were systems which allowed more people to stay in the emergency department on trolleys and more people to go into wards than were supposed to be in those wards because, in the end, conscientious hospital managers, with clear leadership from NHS England, understood that, even though it involved risks, and there was always a danger that something would happen, and that that would lead to an inquiry and condemnation, actually the risk of having too many people in a ward and too many people in the ED was lower than the risk of ambulances taking too long to reach people lying on their living-room floor having had a heart attack. We need to have more conversations of that kind about how we weigh up risk, and we need to be more honest with the public about how we manage risk. That needs to be a context for the conversation about how we get patient safety right.

Q31 **Chair:** Those are really interesting comments. Can we touch on the systems, such as the ICB? As you know, I spoke at your conference last year in Manchester, with Patricia Hewitt, about ICBs, at around the time of the response to Hewitt from Government, which was also a response to our inquiry on ICSs. As you remember, our inquiry was called ICSs: autonomy versus accountability. You could put it another way: leadership versus compliance. The reason it was called that was for exactly the reason that we were putting the question, are ICBs about leadership or are they just a delivery arm of NHS England, and therefore they are about complying with the targets?

Matthew, and then Rebecca, are ICBs well led? I totally take your point that the context is important. Leadership is in the round; it is a corona, and I completely understand that. From your experience of talking to ICBs, how do you feel that system leadership is developing? They are still new, of course.

Matthew Taylor: You quite rightly recognise that they are new. It is really important, in my view, that we stick with the system and let it mature and develop. They are different. As John Morgan, a former chair

of our ICS network, said, "When you've seen one ICS you've seen one ICS," because they are so different in their scale and the nature of their challenges.

I do see great leadership in ICSs. What is the critical leadership factor? I think it is that they have managed to build a sense of collaboration with providers on the one hand, and local government and third-sector organisations on the other. As Gordon Messenger said earlier, to achieve that collaborative framework in a system that is under enormous pressure is very difficult. If I take, for example, social care funding and the issue of hospital discharge, in many places it has proven incredibly difficult to maintain a positive relationship between the health service and local government because both sides face impossible challenges, in particular the challenges associated with hospital discharge.

The critical thing is the quality of those relationships. The thing that gives me a sense of hope is that in many ICSs we are seeing a broader conversation about health. We are seeing a desire to achieve structural change. We have been talking for 20 years in the health service, for example, about how we move a greater proportion of spending out of the acute sector upstream into primary, community and prevention. It is incredibly hard to do that when the acute sector is under such pressure, but at least ICSs are trying to grapple seriously with that issue.

A distinction is sometimes made between system and trust. I welcome the fact that most trust leaders now have place or system leadership roles, and that is leading to a change of mindset. I think good progress has been made but made in challenging circumstances.

Q32 **Chair:** That is really interesting. Rebecca, a very senior MP said to me recently in conversation about ICBs that what we need is reality on the ground and local information, not unfounded optimism. I know where they were coming from. We often do get unfounded optimism from ICB leadership, who want to present a positive picture to MPs of how it is going. But unfounded optimism in a healthcare setting can be very dangerous, can't it?

Rebecca Hilsenrath: Echoing some of what Matthew has said, anecdotally and personally my interaction with ICB leadership has been wholly positive. I have really welcomed the ability to engage with a different layer of management when looking at a trust and issues going on in a trust. I don't have a view on ICBs as regards any other structure, but I note that one of the complexities and challenges in relation to NHS improvement is the changing nature of structures, and local structures versus national structures, and the conflict of accountabilities that can sit in that space.

It is critical, in looking at improvement going forward, that we take as holistic a view as possible. We know that there is a direct line from the top leadership all the way down to frontline patient safety. We also know that it is very difficult to design a successful intervention at only one part

of the system, for some of the reasons that Matthew was talking about. I completely welcome that overarching leadership and I support the view that we should let them bed in. Constant change is the enemy of improvement in the NHS.

Q33 **Chair:** Amen to that. Finally, the outgoing ombudsman said, "The detriments that people experience are significant and should not be happening. In significant areas—in maternity care, mental health, avoidable death, sepsis, eating disorders—time and again I've come across stories of people who only want the truth about what happened to their loved one and they found it very difficult to get it. That's my job—to get at the truth." That does not speak well to leadership, does it? What did he mean by that?

Rebecca Hilsenrath: To go back to where I started, we look at complaints across the NHS. We look at complaints that have already been through local resolution. By definition, if we look at a complaint, the person who has come to us is not happy with how it was looked at locally.

We published a report last summer called "Broken trust". We laid it in Parliament. We looked at 400 recent cases and identified 22 cases of avoidable death. Every single one of those cases had not been properly recognised at local level, or they would not have come to us. In those cases, not only had families lost someone they loved but there was a compound trauma because they had not been listened to, the issue had not been recognised and there had been no learning. That obviously stops you moving on. It stops you grieving properly, and it takes an enormous amount of time and effort to be able to pursue the goal to come to the ombudsman. We recognise that.

We also recognise that it is such a difficult thing to do that the number of cases we see will not represent the totality of harm. Coming back to my previous answer, it is the ability of the NHS to learn and improve that will be critical to its wellbeing going forward. You talked about reviews. There have been a number of them recently, including in the maternity space. The critical piece is that they are making the same findings time and time again, and they are not addressed.

The East Kent report by Bill Kirkup started with an open letter saying that everything he was saying he had said seven years earlier in the Morecambe Bay investigation. That is the issue. Why aren't NHS trusts learning? I think a big part of it is what we see in the cases that come to us: people have been met with disingenuity, defensiveness and a sense of being batted away.

Q34 **Chair:** As you know, we share that concern, which is why we asked the expert panel to produce a report based on exactly that: patient safety recommendations made by public inquiries and where we are. That is a matter of record. They said that requires improvement.

Matthew Taylor: Chair, could I comment very briefly? I think you commissioned a really good piece of work. I want the Committee to avoid, however, the impression that nothing has happened. We have had the "freedom to speak up" champions, which is a very comprehensive initiative. We have the "fit and proper person" test. We have the new patient safety incident response framework, PSIRF, which is about trying to create less blame-focused conversations in relation to incidents. Just yesterday, we had announcements by medical examiners. We have the implementation of Martha's law. It is not that nothing is happening.

Chair: A hundred per cent.

Matthew Taylor: In a way the question is not so much why is nothing happening as why, when all this is added together, doesn't it seem to shift the dial?

Chair: Of course, my question was not why nothing is happening. If we and our expert panel had felt that, then it would not be "requires improvement" but even worse!

Q35 **Rachael Maskell:** Rebecca, the PHSO and the Patient Safety Commissioner wrote to the Secretary of State on 9 February, particularly highlighting "too many incidents which have not been adequately investigated or acknowledged." It highlighted that "there are countless oversight bodies involved in holding the NHS to account and scrutinising it when things go wrong." They also highlighted the complexity of the system. We have just talked about repeated complaints or repeated CQC reports. We see the same issues coming up time and time again. What response have you had from the Secretary of State?

Rebecca Hilsenrath: We are still waiting to hear from the Secretary of State at this point.

Q36 **Rachael Maskell:** In that case, what are you hoping to elicit from the letter that you wrote?

Rebecca Hilsenrath: We made a number of comments in that letter. Obviously, there is enormous complexity about the difficulties in moving forward, and we recognise that. One of the things that we asked for was a review of the regulatory landscape. It is quite challenging to get the health and social care regulators into one room. It is a very fragmented landscape. To offer a critical view, there is a slightly knee-jerk reaction, when things go wrong, of setting up another body without thinking, "Might this sit with somebody else?"

There is obviously an efficiency issue, but there is also an issue of overlapping remits, confusion and additional barriers. That means that all the individual organisations' voices are weakened. It means there is a lack of ownership and a lack of clarity, and barriers to taking things forward. We have asked for an overview of that, with a view to making it more uniform and easier to work with. We think that would be one of the

things that would help to take forward some of the issues in the NHS when talking about findings not being learnt from.

There is one other thing. It slightly comes back to Matthew's point but also comes back to the letter. We talked about the need for the NHS to listen and to adopt better approaches to complainants and to users generally. I am grateful for what you said, Matthew, because there have been some really impressive and fantastic advances, but they do connect into leadership. You talked about the freedom to speak up regime, which we absolutely support; it is really important. We note from the NHS staff survey results that there are reasons for concern about how much people trust the system and their confidence that something will happen as a result of a complaint, and their security about making a complaint if they have been involved in an issue.

We would say about that, and we would say the same thing about complaints, that it is a leadership issue. If you look at the findings from the National Guardian's Office, there is inconsistency—the word of the morning—about how well supported "freedom to speak up" guardians are and how much time they get. For the system to work well, it is about leadership giving support.

The same thing is true of complaints, which I am happy to come on to. We talked about complaints standards in that letter to the Secretary of State. When we originally looked into complaints, we commissioned a report in 2022 called "Making Complaints Count". As part of the research that went towards that report, we spoke to many complaints handling teams across the NHS. We also spoke to a lot of leaders. A lot of leaders said, "We have a really important complaints handling team and we really value their service." A lot of complaints handling teams said, "Well, we don't get valued, we don't get trained, we don't get support and we don't get developed." There is a parallel thing between the "freedom to speak up" regime and the complaints handling structure. They are great. They all need proper leadership to work.

Q37 **Rachael Maskell:** Thank you for that answer. I want to draw on your written submission, where you say: "A leadership stance that views complaints as a threat or failure will lead to responses that lack compassion and are characterised by defensiveness rather than a willingness to listen and learn." That is a very astute observation.

How do we ensure that organisations move into that listening and learning space? Obviously, that needs to be at the lowest level. In fact, your desk should be empty, and complaints should not be escalated to you. Also, how do we ensure that they are looking for those issues? I recognise that the complaints system is heavily weighted in inequality. If you have less agency, you are less likely to complain. How do we ensure that organisations are looking to address those concerns, and not just waiting to be responsive to those who are able to complain?

Rebecca Hilsenrath: I completely agree. I mentioned the NHS complaints standards, which we rolled out a couple of years ago and which we co-produced with the NHS. They are all about early resolution, a learning culture and ensuring that learning is acted on and reviewed. There are expectations about positively welcoming complaints and about looking at them in a thorough, fair and accountable way and looking at the learning. That cannot be about sitting in your back room and hoping that people will come to you. It has to be a culture within the entirety of the body.

I spoke earlier about an NHS chief exec whom I met, who worked with patient partners who were employed people with lived experience. They had a hub in the hospital, welcoming people. They were talking about taking premises in the town and using one of the charity shops with a high street front to get into the community and take the message out, which I thought was a great idea. It is just an ambition at the moment.

In some of the repeat findings, which I know make very sad reading because they are repeat findings—they will be well known to the Committee—some of the maternity inquiries particularly talk about lack of compassion and lack of listening. There is a critical piece about actually listening to patients, families and loved ones and listening to staff. I think that has to be the place where you start.

I will mention this, and then I am going to pause. In the last session General Messenger talked about teamwork. He talked about the stark difference between the military culture and the NHS culture in terms of what he experienced as a lack of teamwork. You see that in the Kirkup findings where he talked about a group's professionals just not getting on with each other—obstetricians and midwives or whatever. That is a massive barrier when it comes to making a complaint. It is a massive barrier when it comes to escalation and referral. It is a massive barrier to producing a culture which is welcoming and makes patients really feel that they are cared for when what they hear is colleagues dismissing each other. That is always going to take you away from learning.

Q38 **Rachael Maskell:** Matthew Taylor, one of the things that I think I have heard today when talking about leaders or managers is about confidence and being able to act with confidence within the system. That reflects a discussion I had recently with an NHS leader who is not able to bring about change because there is so much pressure being put on the system. What messages do you have for NHS England and for Government in order to ensure that NHS managers and leaders can have the confidence to make the bold decisions that they know they need to make, or even the little changes?

Matthew Taylor: If you look at the literature around what makes for dynamic, continuously improving organisations, you will find that the characteristic they have is that they combine and align different drivers of improvement. There are the top-down drivers, which are to do with

strategy, accountability, resource allocation and those kinds of things—the capacity to intervene when things go wrong.

There are the lateral drivers, which are to do with professionalism, culture, teamwork and values. There are then the bottom-up drivers, which are to do with being responsive to patients, to the public and to the community. That is what creates a dynamic system. If you want the best leaders, you will have leaders who feel that what they are being told to do, what people think is the right thing to do and responding to people aligns and creates a dynamic and improving culture.

The reality is that all NHS leaders suffer from the same medical complaint. They all have stiff necks because they spend all their time looking up. We must create a context in which leaders have more time to learn from each other. One of the things that I found remarkable, coming into the NHS from the outside a few years ago, was that I assumed that because the NHS is big and there are lots of different leaders, the leaders would spend a lot of time in each other's organisations learning about them. They don't. They don't have the time to do it.

If I was running the NHS, I would say that every leader should spend, say, one day every two months in a different organisation, just learning about it and finding out about it. It is one of the reasons why we recommend a stronger element of peer review in CQC inspections. I would also want leaders who had more time to listen to patients and to the public, and to recognise that this is not a problem to be solved but integral to the improvement of quality. If we want the best leadership, we do have to reduce the amount of central control and compliance. If nearly all that boards do is worry about compliance—this is not just about leaders but about boards—you are going to get compliance and not leadership. That is one of the reasons why, I think, ultimately, the NHS is not as responsive or dynamic as it needs to be.

In my own organisation, the NHS Confederation, we are turning ourselves from an advocacy organisation into one that is around how we strengthen peer-to-peer challenge and improvement. That is the missing element in all of this. I know that when leaders sit round a table listening to each other and looking at data, they really can learn a lot; but they rarely do that. They are more often in rooms where they are being told, "This is the way to do it. Now go back and comply with this list of instructions."

Rebecca Hilsenrath: I agree with that. Safe spaces and psychological safety apply to leaders as well as to those they lead. I will quickly mention anecdotally three behaviours that we have seen at leadership level. One is a concern about findings about an NHS trust because they were worried that it would damage reputation and patients' willingness to be treated at that hospital, as opposed to accepting the recommendations and making improvements. The second was refusing to accept the financial recommendations that we made because they were worried about their budgets; and the third was not accepting findings of avoidable

death. All those things are the act of somebody who is scared, who is under too much pressure and is not really thinking from a balanced, sensible space about what is the best thing to do.

Q39 **Rachael Maskell:** I have one quick question to you, Matthew Taylor, before closing. Obviously, for leaders in the NHS, there are many things, as we have discussed today. We are also seeing incredible changes in medicine. We are seeing a turbulent political space and many societal expectations rising, perhaps beyond the reality that can be delivered. How do we ensure that we have leaders who are able to address those issues? That is also about creating a safe environment through which people can enter.

Matthew Taylor: Rebecca talked about the proliferation of different regulatory bodies such as the Care Quality Commission, the Healthcare Safety Investigation Branch, the national "freedom to speak up" guardian, the Patient Safety Commissioner, the Parliamentary and Health Service Ombudsman, Healthwatch England, local authority overview and scrutiny committees, NHS England and professional regulators. I could go on.

That is all happening, but we need to give leaders the greatest scope to speak openly to their public. There is an interesting contrast between local government and health. Local government has had to make incredibly difficult decisions—we both live in the same city, after all—over many years. But it has done it, by saying to the public, "We have a limited resource and therefore we are going to have to close the library"—or do this or that—"and focus our resources on our statutory requirements."

Health service leaders don't have that legitimacy. I don't think they often have the permission to have those open conversations with the public. Through integrated care partnerships, there is scope for us to learn from local government and to have more open and honest conversations with the public. That is partly being honest with the public about risk, but also about the role the public themselves can play, because they are critical to improving the quality of what goes on in the health service. The empowerment of patients is absolutely central to the future of the health service. The innovations that most excite me are those that empower patients and give patients a greater sense of agency.

When I speak as a representative of leaders, I don't want to reduce accountability. I want more accountability downwards and outwards, and less compliance upwards.

Chair: Thank you very much. We have about half an hour left before we finish at 12.

Q40 **Mrs Hamilton:** Good morning, both. Matthew, I have two clear questions. One is for you, and the second is for Rebecca.

Matthew, it was music to my ears. I know how you and others such as

the King's Fund think because I do that work—I don't know if I should declare it—where I sit down and work with NHS leaders about some of the issues they are having, and I see the hesitation and the difficulties that they are grappling with at this moment in time. I will start there.

Matthew, you made a fantastic point, and you keep saying it. You say that we need to be more open to the public about risk and patient safety, so this is my question to you. We have talked about regulating managers and leaders. Is the registration and regulation of NHS managers by a professional body, or a college or equivalent, now needed to achieve better patient safety, where patients can really understand what the risks are, and to improve operational efficiency?

Matthew Taylor: I will try to be brief. I think NHS leaders are entirely open to the idea of some kind of regulatory framework for NHS managers, although let's remember that more than half of NHS managers are already regulated as clinicians. There are two things. One is that we need to be really clear about what we are trying to achieve and the relationship between professional standards and other issues around, for example, leaders who have failed and then been disbarred. What exactly is it that we are trying to do there?

Secondly, I would absolutely echo Rebecca's point. If we are to create something new—some new way of recognising and regulating leadership—let's put it in the context of all the other regulatory systems. Let's not do what we always do, which is just to add another ingredient to the soup in the hope that it will improve it. Let's stand back and say, "What are the ingredients that are most likely for success?" Yes, we are open to it, but let's look at it in the overall context of regulation and make sure that if we do create a body of that kind, we are clear about what we want it to achieve.

Q41 **Mrs Hamilton:** This is my last quick point because it really touched me. I think it is the point of the day. You said that we need to be open to the public about risk. If there was one clear thing you wanted to say to this Committee that we need to recommend, to ensure that we are doing just that and being open to the public about risk, what would it be?

Matthew Taylor: It would be that the avoidance of risk does not always improve the overall outcome for a patient. I can give you an example. During the junior doctors' strikes I have visited hospitals. Hospitals feel like, in some senses, more functional places when junior doctors are on strike. That is because the consultants are not doing their out-patient clinics or whatever; they are in the hospital, which means, in some ways, that the hospital runs more effectively. It also means that the backlog—the waiting list—is building up.

The reason for that is that more senior members of staff are more willing to take risks; they have greater confidence in doing that. I was in a hospital a couple of weeks ago where they had people in the emergency department awaiting medical assessment. Those people were

overwhelmingly elderly, frail people. The hospital manager said, "If my consultant gerontologist is on duty, he will go down this line of patients and he will work out how to discharge each of them"—to *discharge* each of them—"because he knows that to admit somebody like that—an elderly, frail person—to hospital is almost never good for them. It will lead to them being deconditioned and could lead to them also getting trapped in hospital," which is a real issue for the hospital and its resources and so on. If, however, a junior doctor, less experienced, under pressure, goes down the line, they are quite likely to recommend that patients have tests, which could be intrusive, and it is likely that a couple of them will be admitted, because the risk of admitting is much lower than the risk of discharging, and then that patient dies and the relatives understandably say, "Well, you didn't do the right thing."

I spoke to another hospital leader the other day. It is an anecdote, but he said they had been into a maternity ward, and it felt that an enormous amount of time now was being spent on compliance rather than being spent with patients. I don't want to test the truth of that—it is one story—but what I want you to understand is that sometimes the systems that seek to minimise risk do not lead aggregately to the best outcomes for patients. That is something I don't think we always give proper consideration to.

Q42 **Mrs Hamilton:** Fantastic. Thank you. My very last point is to you, Rebecca. It is in your area of work. The Parliamentary and Health Service Ombudsman expressed concern about the impact of introducing further regulation of NHS leaders in "an already complex and overstretched system." I think you have articulated that clearly. Let's bring it back to Joe Bloggs. How will residents ever get confidence in a group of leaders where additional regulations are being resisted?

Rebecca Hilsenrath: Thank you for the question. I won't repeat what I said. Matthew has articulately talked about the need not to place more burden on an already complex and over-complicated system.

There is a point of substance as well. It comes back to the previous panel and what General Messenger was saying. It is actually not the job of the regulators to improve leadership in the NHS; it is the NHS's job. Yes, you could look at a different system and you could consult on it and make sure that it was connected up to other sectors, and so on and so forth. You could try to deal with the fact that it is already an over-complicated system, but that is the wrong end of the equation. I think you need to start by saying, "What does good leadership look like? What standards are we setting out? What culture do we want?", and worry later about whether you then want additional regulation to ensure that you have got what you asked for. I think that is the starting point. That is where I think the conversation needs to be.

Q43 **Mrs Hamilton:** I will hand back to the Chair in a second, but I have to ask you something else. We are struggling out here as the public. Everything that you are saying makes absolute sense to somebody like

me who understands the health service. To somebody who is out there listening to this today, a lot of it sounds like we are protecting ourselves: mistakes are still happening, things are not going the right way, and all we seem to be doing is making excuses.

If there was one thing you could give us, as a Committee, which the Parliamentary and Health Service Ombudsman would like to recommend—among all the flurry of things you guys have talked about today—to help residents out there to understand the direction of travel, what would it be? Matthew articulated all the different committees and groups. People are just confused.

Rebecca Hilsenrath: It is a very good question. I think the vast majority of people out there who are listening to this session don't know anything about the health service regulatory landscape—I hope not. It sits away from their experience of the NHS.

The critical difference that will be made to people who are NHS users is an improvement of their communication with the NHS. The feeling that comes across in our casework over and over again is poor communication. It comes up in the Kirkup reviews and in other areas of investigation. It is not just about what happens when things go wrong, which is critical, where we see a lack of transparency. It is also about what happens before then, when people are giving views about what is going on with themselves or their loved ones and they are not listened to. A case in our "Broken trust" report was about a man who came to an emergency department multiple times with his mother. The symptoms were not listened to and were not taken seriously, and she died of a stroke, which was entirely avoidable had they been listened to and had treatment been administered earlier. It is all about being listened to and being communicated with, and having that honesty of engagement.

We welcome the Government's agreement to review the duty of candour, which for some time we have said is not being properly implemented. We called for that as part of our "Broken trust" report, and we look forward to contributing to it. We think it lies at the heart of the trust between users of the NHS and the people they work with.

Mrs Hamilton: Thank you, and thank you, Matthew. Chair, back to you.

Chair: Right, super. We have 20 minutes and two people. Do the math, as they say.

Q44 **Paul Blomfield:** Returning to the theme that I explored with the first panel of the role of whistleblowing in patient safety, I recognise that that is just one strand, and I very much recognise your points, Matthew, about safety and risk. Nevertheless one of the things that shocked the general public when they looked at the Letby case was that people knew things were going wrong and voiced those concerns, but they were not heard. The stats, which I will not repeat, from last year's NHS survey, indicate that that remains a significant problem. I think those numbers

were worse than they had been in the preceding four years, so it is going in the wrong direction. What reflections, starting with Rebecca, do you have on how we address that point and shift the culture?

Rebecca Hilsenrath: Thank you for the question, which is really important, and for using the phrase "just one strand". I would start by saying that the strands are quite interwoven. In listening to concerns about the NHS I would say that there are three core channels. There are probably others, but I am going to group them into three. I have already talked about listening to patients, families and carers. We have already talked about listening to staff, in terms of the "freedom to speak up" guardian regime. We have also talked about other initiatives, like Martha's rule, which goes back to families and patients. Then there is whistleblowing. They are kind of interwoven, because if one bit doesn't work there is more pressure on the others. If we listened more to patients and staff, we wouldn't need whistleblowers. If we listened more to staff, we wouldn't need to place so much burden on patients' families. It is quite important to see the landscape as a holistic one.

There have been a lot of quite well-publicised cases of whistleblowing. Moving away from the Letby case, Dr Peter Duffy resigned from the NHS last year after a 42-year career. That was on the back of being referred to the GMC on numerous occasions, and an employment tribunal. This was somebody who had been elected as the best regarded doctor in his trust and who was given an MBE for services during the pandemic. He was very well regarded. Just last week there was a report of 105 cases at the Royal Sussex being investigated by police, on the basis that earlier whistleblowing claims had been dismissed as being made "in bad faith".

This comes up a lot, and when it does we see a lot of defensive action by the NHS. It undermines trust because every single one of those headlines has patients and families out there thinking, "Something is going on. Why is so much energy being diverted into trying to silence the whistleblowers as opposed to looking into what is going on in the first place?" Something isn't working, in terms of balance. There is a view that the legislative framework is outdated and needs to be looked at. In Scotland, the Scottish Public Services Ombudsman has powers in relation to whistleblowing. There have been numerous private Members' Bills here to look at setting up some national office for whistleblowers that would have powers to set standards, provide information and advice and, critically, force compliance where organisations don't have a proper infrastructure to support whistleblowers, and maybe also to initiate prosecutions. That is an important conversation.

At the moment, without consistent—that word again—support for whistleblowers, when you see the headlines, it breeds distrust.

Q45 **Paul Blomfield:** Matthew?

Matthew Taylor: I agree with every word of that. I want to add two points, but that is not to take anything away from what Rebecca said.

First, hospitals, and other NHS trust systems, are big and complex organisations. There are an awful lot of complaints and staff concerns, so it is not simply about how you respond to all of those. It is about how you have the mechanisms to understand whether they are fair and right, and what should be done about them. That is a capacity challenge, so it is not simply a matter of everything being fine, and then someone complains about something, and it is ignored. There is a constant background noise of people having concerns about what is happening, because we are dealing with life and death situations and, unfortunately, we in the health service are not at the moment able to meet the expectations that the public have. We know from staff surveys that many staff—we saw this last week in a survey of why doctors are leaving the NHS—are unable to provide the level of care which they came into the service to provide. That is a kind of endemic experience for them.

So I absolutely agree. As I said earlier, the leaders I speak to recognise that responding to patient and staff concerns is not a kind of hygiene factor away from the main business of improving the quality of care. It is intrinsic to it. It is one of the ways in which we can and should drive change in the organisation. But I wouldn't want us to underestimate the capacity issues that are involved in responding to the level of concern that exists in a large organisation dealing with life and death issues, where staff very often feel overstretched all the time.

Q46 **Paul Blomfield:** Thank you very much. I take that point. Rebecca, you talked about defensiveness. The NHS is not unique. Big organisations, and small organisations, are instinctively defensive when challenged and I guess that the challenge that the NHS has is how it overcomes that and recognises that with, say, patient complaints there is an overlay of grief sometimes, and trauma, which looks for blame where it does not exist. There is an instinct, as I think Rebecca put it, of not learning from mistakes. How do we get past that, Matthew?

Matthew Taylor: It is your role to ask questions, not mine, but I wonder to what extent you think that part of the challenge of speaking up is that people are more likely to speak up if they think something might happen as a consequence. It isn't just that you need to feel safe about speaking up; you need to feel that there is a point to speaking up, in terms of—

Q47 **Paul Blomfield:** The NHS survey demonstrated that people felt neither.

Matthew Taylor: Yes, exactly. I don't want to be a broken record, and I am not saying this is all just about resources. There are important issues about leadership and patient safety and all those systems, but part of this is that staff have to feel it is worth making a complaint and taking the risk that might be involved in speaking up, because they think there is an opportunity for things to improve; but if you think, "This is simply the reality that we have to cope with," that is going to discourage you, because you have the hassle, but there is not much chance that a great deal will change.

Q48 **Paul Blomfield:** Can I follow up on that in terms of a point that you made earlier? You said that too much time is spent "looking up" in the NHS. You talked about ICBs and the tension regarding a report between the NHS and local government. When I talk to my local ICB, every month or so, they are kind of dealing with that, and it is in-built in the system, but the real tension seems to be between local decision making and nationally imposed decisions. You are nodding at that, and I think it kind of reflects what you were saying. I wonder how far there is a culture at a local level of "What's the point of us speaking up, because we are a top-down organisation and judgment locally is not respected?" Is that a factor?

Matthew Taylor: I certainly think that the culture of the NHS is one where, if leaders are frank about the challenges that they face and the risks they have to balance, it is not particularly career-enhancing, partly because of the accountability issue. It is not clear what your local accountability is; it is clear what your central accountability is. I want to emphasise the issue of the central, kind of hierarchical nature of things. NHS England is doing really important work to rethink its operating model and to try to be more permissive and respond to the way in which systems work, but the politicised nature of the health service is the big issue.

One of the reasons why we protect the NHS, and why the public care so much about its principles, is that it is this national institution, and it is something that we feel politically deeply about, but the flip side of that is constant short-termism and the fact that, as we all know, it was political horse trading that led to planning guidance being published the day before the planning year began, which everybody knows is complete nonsense. The relationship at the very top of the health service—the politicised nature of it—does take up an enormous amount of energy, which could be better used, in my view, in cultivating those local relationships and engaging with the public. As Patricia Hewitt argued in her report, which you commented on in your own report, with remarkably similar kinds of conclusions, we created integrated care systems and new integrated care partnerships, but we haven't yet created at the national level the kind of operating model that goes with the intentions of those integrated care systems.

Paul Blomfield: There is a lot more to explore there.

Chair: Yes. Thank you very much.

Q49 **Dr Johnson:** I want to come back to what you said about risk, Matthew, because the balance of risk, particularly in relation to ambulances and ambulance transfer times, is something I have advocated on as a Back Bencher and briefly as a Minister. The people at most risk are, obviously, those who don't have their ambulance yet, but if you run a risk-balanced system, inevitably you have increased the risk somewhere in order to spread it out more evenly, and that will have an adverse consequence on an individual somewhere, even though the overall effect may be to make

it safer for the population. For the individual, it may not always be so. We also have a tendency to judge people through a retrospectoscope and say, "Well, it was obvious," rather than recognising that hundreds of people came with the same symptoms, almost all of whom did not have a serious problem. That can lead to defensive medicine, which, as you have alluded to, leads to unnecessary investigation and an opportunity and resource cost for other people. How do we get that balance right?

Matthew Taylor: That is such a brilliant question. The very recognition of the need to get the balance right, and that that is the responsibility of leaders, and that we need to give leaders the scope to be able to get that balance right, and to talk explicitly and openly about how they are trying to do it, would be what I would recommend to you. I think at the moment it is quite difficult to do that because we have a culture in which if you are on the board of a system or a trust, and you have things you have to comply with, you don't have the scope to say, "I'm going to comply with 80 of them, but I'm not going to comply with the other 30. I just can't do that." You have no ability to say that. You have no accountability mechanism that would allow you to say, "On behalf of local people I am doing that," or, "On behalf of my local partners I am doing that."

I think what you have said is absolutely right. I encourage the Committee to explore how we can give leaders more permission to lead in opening up some of those debates and engaging the public, their staff and others in those kinds of conversations. That is what leadership should be all about.

Q50 **Dr Johnson:** Thank you. Yesterday, the Cass report was discussed in Parliament. There was a statement by the Secretary of State. Many things were highlighted in it, but one of them was the failure of managerial staff and senior leaders in the NHS to make people comply with contractual compliance things. For example, the Cass report wanted to look at the outcomes for children who had gone through the GIC clinic at the Tavistock and had then gone into adult care. There was a refusal by some people working in adult care; even with the protective blanket of a specific SI in Parliament to give them legal cover to make sure they could do so, and even with direction from NHS England to the trusts and the letters from the specialist commissioning officer, they still did not provide the data. Is that because managers do not have the levers to enforce compliance? You have talked a lot about compliance. Is that an example where they do not have the levers to enforce compliance even if they want to?

Matthew Taylor: I have to admit that I would need to know more about the specifics in relation to that. However, I would say that data is an extremely important part of this—the more we can have accurate and credible data and the more we can open up that data and share it with the public, the better. I think that generally people in the health service want to do the right thing and if they think there is credible and strong data that identifies the fact that outcomes are not successful, or they are performing much less well than the average, people will want to respond

to that. You raise an important question about the capacity for managers to ensure compliance in particular circumstances and it is one I will have to take away and look at. Rebecca may have more to add.

Rebecca Hilsenrath: I wouldn't be able to speak to the specifics of the case. Broadly speaking, I note that some of the findings that you see repeatedly in the investigation are about a lack of ability to follow basic national clinical guidelines. I don't know whether there is a read-across there in terms of capacity and time, but I don't have knowledge of the specifics to talk to the case that you mention.

Q51 **Dr Johnson:** You mentioned data. The NHS in itself is a goldmine of data because virtually everybody accesses the same health service and has an NHS number. The anonymous data that the Government should really be able to use to improve patient care is not being used to its fullest advantage, in my view.

I have a question about people's understanding of the leadership structure. In the Lucy Letby case, seven paediatricians wrote to their senior managers in the trust to raise concerns about what was going on. Sadly, a number of babies died. The question then became why, when seven paediatricians all said the same thing, they were not listened to. Rebecca has talked about being listened to. Do you think people understand where the next step is? If the trust board doesn't agree with them and they think there is a problem, where can they go if their trust board is not listening? Do you think it is clear who they would go to next?

Matthew Taylor: I will respond to that, but do you want to go first, Rebecca?

Rebecca Hilsenrath: When you say "people", do you mean the paediatricians?

Dr Johnson: No. This is one example; I am sure that if you look in detail there may be other, less high-profile examples. This is an example where a group of individuals were banging their head against a brick wall and raising concerns and not being listened to, with desperately tragic consequences. Where do they go if their trust board is not listening to them? Where would they find an organogram that shows them that if it is not listening they should go here or there? Where do they go?

Rebecca Hilsenrath: In a well-run trust that will be very clear, because if your objective is to make sure that you have all that information, and you are listening to your staff and promoting the escalation of safety concern issues, you are making it very clear to people what the pathways are. Not only that, but you have a board that is able to understand the granularity of what is going on, where necessary, so they are engaged in those communications and have sufficient understanding to engage with and listen to safety issues. That ought to happen proactively.

Q52 **Dr Johnson:** Wherever you have difference you will have variations of good and bad. The Tavistock had an "Inadequate" rating and I am not

aware that any manager has been sacked from the Tavistock for that rating. The report from yesterday speaks for itself. In the Letby case, there were tragic consequences when paediatricians en masse were not listened to. It may be that if the trust is well run it is all very simple and straightforward, but trusts will never all be well run because in reality you will have difference and people who are not good at their jobs. Where do they go next?

Matthew Taylor: It is important to have clear responsibility—that it is clear that there is somebody on the board who is leading in relation to patient safety, who is someone that ultimately you can go to if you feel that all other avenues are closed to you.

Q53 **Dr Johnson:** What if they don't listen?

Matthew Taylor: If you go through the board and they don't listen, we have other mechanisms. We have the "freedom to speak up" guardians, so that is one route. You can go through your professional organisation. It is not a situation that we should be getting to—that you feel that there is absolutely nowhere that you can go within the organisation. We have put in mechanisms to try to ensure that that isn't the case.

We will look forward to what comes out of the inquiry into the Countess of Chester in particular, because you identify a very important question, which is what happens when it feels like you have exhausted every avenue. Generally speaking, the ways in which you escalate these things are laid out. Whether or not they always work is another matter, but I think that, generally, well-run organisations will be clear about the process and where you can go and where you can finally take it to board level if you feel that nobody else is listening.

Rebecca Hilsenrath: Hence my comment earlier about the interconnectivity between listening to the various stakeholder groups. Ultimately, yes, you ought to have better support and infrastructure for whistleblowing, but that ought not to be where we are focusing. We ought to be making sure that it actually works, given your point that it will never all be perfect, but I suspect there is more room for improvement there, as a starting point.

Matthew Taylor: If people in the end feel that they have to go outside the organisation to the police or the media, or anybody else, it is a sign of failure in that organisation; there is no question.

Q54 **Dr Johnson:** If the Chair will allow me one last very quick question, Rebecca, at the beginning you talked about sharing lessons, and it seems to me that in such a massive organisation there will be lots of things to learn. If you group them together, they become in some ways so generic that they are not necessarily all that helpful for people to listen to and are quite repetitive. When they are quite specific, they may be more useful but they are more difficult to share because there are so many of them.

For example, as a paediatrician, in my very first paediatric job, I left a

baby one day and went home and there was a mistake made by the registrar after I had left that had a very poor outcome for that individual child. Every time I teach junior doctors about that specific process I tell them about that specific baby, not with details about the person, but the story of what happened. But I cannot very easily share that detail with every other paediatrician in the NHS, and neither can everyone who has a similar story. How do we get lessons to be specific enough to be useful to the doctor or nurse or other clinician, and not so generic that they just become bland, while recognising that there are so many different lessons to learn that we would have to sit and read for days and days to go through them? How do we select them, and get that right?

Rebecca Hilsenrath: That is part of learning, though. If you have a culture of learning and wanting to improve, you frankly find a better way to disseminate that information. You should not be scrolling through loads of papers and long reports, and bibles of cases, or whatever. The organisation should be saying, "We recognise that that is critical learning, and we will find a way of sharing it that makes it accessible to people in their real lives in their professional contexts."

I can give a couple of examples of a completely different kind. One is about interventions that have been designed around making sure that all policies in a hospital are absolutely updated, so that if you go on the website you get the latest whatever it is, without understanding that, because of poor wi-fi, staff were downloading outdated hard copies and using those because they come to hand. There is something about recognising what people are actually doing on a day-to day basis and making sure that when you promote learning you understand how people can reach it and learn, and the best way for them to understand it.

I come back to a point I made earlier. I am sorry to dwell on it, but we see a lot of it and it is important. We often see a case where somebody has died as a result of poor treatment for whatever reason, but the person had an underlying condition which would have meant that at some point in the near future they would have died, perhaps in a matter of months or years.

We quite often have a debate about whether that is an avoidable death; but that is the wrong conversation to have. For a start, it is not the death they should have had. It is not the warning their family should have had. They haven't had the quality time to say goodbye, and therefore they can't heal, and get over and accept what has happened. Instead, the trust says, "Oh, no, it wasn't an avoidable death," so the learning from that never happens, because they are too busy batting away a grieving family who need to find a purchase on the truth of what has happened, instead of looking at, I suppose, their statistics in terms of avoidable deaths.

It is a cultural thing. It is about trusts and the NHS saying, "Okay, we're not going to worry about being defensive. We're going to ask what actually happened and how we fish that out of this case and make sure

that everybody understands it, because it is really important." If you say, "No, it wasn't an avoidable death, because she had cancer anyway," no one is ever going to learn from it; no one is ever going to be given the facts and share the importance of it, because the trust says it isn't important—she was going to die anyway.

Q55 **Dr Johnson:** With respect, you have gone back to trust level again, haven't you? For me, I do not now work in the trust where I was working when that happened, so I can share the information, and other doctors can share information in the places where they work, but that does not stop someone in Cornwall having the same problem, because none of them worked there. How do you spread things out so that you do not have the same mistakes being made in different hospitals around the country?

Matthew Taylor: I think there are different mechanisms. We now have the new PSIRF system, which, when things go wrong, is supposed to enable us to understand what has gone wrong in a way that is not around blame and is around learning. The critical thing is learning. We also have programmes like GIRFT, which are around looking at data to ensure that we do things in the best way we can. Your point is absolutely right. We have to understand what the nature of the learning is. Is it organisational learning around the culture of one specific organisation, or is it learning that can contribute to rethinking the way we undertake a particular clinical pathway? We need to be clear about that.

In response to Rebecca's point, as I suspect this will be my final contribution, you are absolutely right when you talk about avoidable deaths, but I also often hear from people that their loved one had indicated they did not want more interventions. They did not want to go back to the emergency department or be admitted to hospital. They had made that clear in their care plan, but still the way the system worked—often in a risk-avoidance way—led to interventions and admissions that they did not want. That is part of the story as well. How do we ensure that when people are clear that they have reached a stage where they want to minimise medical interventions and return home, if they can, and be with their loved ones, we can give them the dignity that they want?

Rebecca Hilsenrath: That comes back to communication again.

Matthew Taylor: Absolutely.

Chair: Thank you both. This has been a good start to the inquiry, I hope. I am grateful to Matthew Taylor and Rebecca Hilsenrath for your evidence. It is a big day in the House of Commons. Downstairs on the main channel at half-past 1 there will be the Tobacco and Vapes Bill, where people watching can see NHS leadership in action—from the Prime Minister this time.