HOUSE OF COMMONS

Health and Social Care Committee

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

Tuesday 21 May 2024

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Watch the meeting

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

Questions 56 - 97

Witnesses

I: Dr Jayne Chidgey-Clark, National Guardian for Freedom to Speak Up, National Guardian's Office; and Miles Sibley, Founder, Patient Experience Library.

II: Dame Linda Pollard, Chair, Leeds Teaching Hospitals NHS Trust; Professor Kamila Hawthorne, Chair, Royal College of General Practitioners; and Sam Allen, Chief Executive, North East and North Cumbria Integrated Care Board.

Written evidence from witnesses:

– [Add names of witnesses and hyperlink to submissions]

Examination of witnesses

Witnesses: Dr Chidgey-Clark and Miles Sibley.

Q56 **Chair:** Good morning. This is the Health and Social Care Committee, back for the second day in a row. It is Tuesday 21 May, and we are in Committee Room 16 in the House of Commons today.

This is the second oral evidence session of our big inquiry into NHS leadership, performance and patient safety. That and productivity in the NHS is our focus. Today we are particularly focusing on patient safety. This session is going to look at how good leadership differs at different levels of the NHS. We are going to look at leadership standards over the NHS in recent years and the effectiveness and mechanisms for speaking up in the NHS. Clearly, it could not be more topical.

We have two panels today. We are going to finish both of them by 11.30. Panel one, in front of us now, consists of Dr Jayne Chidgey-Clark, who is national guardian for freedom to speak up at the National Guardian's Office, and Miles Sibley who is the founder of the Patient Experience Library. Thank you both for coming.

We should start where yesterday left off. You will have seen, obviously, what was said yesterday. There will be more that is said today in this place. The East Kent report by Bill Kirkup, which I am sure you know, started with an open letter saying that everything he was saying he had said seven years earlier in the Morecambe Bay investigation. That, to me, seems to be the nub of the issue. We heard a little bit yesterday about lessons learned. We will hear it today, constantly. Why don't we seem to be learning lessons?

Dr Chidgey-Clark: Good morning. Thank you very much, Chair, for the kind invite to present today. It is a real privilege. It is such an important topic that you are considering.

Why is it that we are failing to learn the lessons? It is very complex. One of the clear things that is broken is culture, and culture takes a long time to change. Report after report has shown that we need cultural change. It is not the processes, the procedures or the policies; they are an important underpinning, but it is cultural change to put patients at the very heart of what we do, over and above performance and finance. Those are very important, but if we do not put patient safety and patients at the very heart of what we do, and therefore the same amount of effort that we put into performance and finance, that is why we are failing to learn the lessons. It is very complex and I could talk a lot longer, but I will start there.

Q57 **Chair:** Miles, for the benefit of people watching, tell us in a sentence what is the raison d'être of the Patient Experience Library? Then, give us your reflections on yesterday in the context of the question I have just asked.

Miles Sibley: The Patient Experience Library is an online research database gathering written studies and reports on people's experiences and involvement in healthcare. We set it up because we noticed that an NHS which says that it wants to be both patient-centred and evidence-based did not have a coherent all-in-one-place evidence base for patient experience. We built the library to fill the gap. It is open access and free to use.

On the question of why we are not learning the lessons and why we keep seeing the same things happening over and over again, from Mid Staffs through to Morecambe Bay and on through Shrewsbury and Telford, East Kent, infected blood, medicines, medical devices and all the rest, I would point to two or three things. First, Bill Kirkup himself, in the East Kent report, pointed to the multiplicity of inquiries, each one of which comes out with dozens and often hundreds of recommendations. This leads to confusion. There is research that describes NHS managers faced with all of these reports and inquiries having to contend with "priority thickets". They get lost in hundreds and hundreds of recommendations. Kirkup himself said that there are too many of them; there are too many overlapping and sometimes conflicting reports and recommendations. It is hard for people to make sense of that and know what to do with it. That is one part of it.

The other part of it is this. If we are talking about learning from lessons, one of the key lessons is to listen to patients and families when they are speaking up, as well as staff. In every single one of these instances people have been speaking up, sometimes for years—as we have seen with infected blood—before they are finally believed. The people charged with hearing the patient voice and learning from what people are saying—the PALS teams, the complaints managers, the people in all the 150 Healthwatch teams across England and so on—are almost unique in the NHS workforce in having no professional qualification. Clinicians cannot practise without a qualification. Finance managers in the NHS are qualified. HR people and the caterers have qualifications, but patient experience people, listening to the patient voice, are not qualified and there is no professional development for them. On top of that, they have no analytics to help them make sense of all the data that they are faced with. Data comes from the friends and family test. In March 2024, across England nearly 2 million comments came through the friends and family test—in one month alone.

There are the national patient surveys. Thousands of Healthwatch reports have been published every year. People doing patient voice work have no analytics to help them make sense of that data or to understand what it is telling them. We often hear in some of the inquiries about complaints handlers, for example, simply processing complaints and trying to resolve them within time deadlines rather than learning from them. There is a failure within the patient voice piece of the NHS workforce to be properly supported and properly trained. The Parliamentary and Health Service Ombudsman, in a report a few years ago called "Making Complaints

Count", points to the fact that complaints managers are poorly supported and often lack the kind of training they need to make sense of complex issues.

Q58 **Chair:** You seem to be suggesting that people are trying to process or get stuff off their desk and move on.

Miles Sibley: Exactly. That is happening at the frontline of patient voice. People with no professional qualifications are trying to do that work and trying to meet their processing deadlines. At the more strategic end, NHS managers are faced with inquiry after inquiry, year after year, with hundreds of recommendations, and they just get lost in the system.

Q59 **Chair:** That is consistent with what Matthew Taylor, chief executive of the NHS Confederation, said to us: "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?" I guess that is the patient experience. There are all these well-meaning bodies, some of which have lots of professional qualifications and some of which have not; everybody is well-meaning—well, not everybody if you read yesterday's report, and I suspect that there are things coming for them—and there is an awful lot happening, but nothing is really changing.

Miles Sibley: It does seem that way. Going back to Jayne, the national guardian produced a report last year on staff experiences of speaking up. It was called "Fear and Futility". There is a sense that people are afraid to speak up, but also a sense that if they do, nothing will change. That was talking about staff experience, but exactly the same is true for patients. You can go back to 2013, in the wake of Mid Staffs, when Ann Clwyd MP produced a report called "Putting Patients Back in the Picture". She talked about exactly the same thing for patients. There is a sense of fear about speaking up, but there is also futility: "What difference is any of this going to make?" There is a huge perceptual problem.

Q60 **Chair:** Jayne, it was your report, and presumably you agree with your own report. Let's explore the futility point, briefly. That means that people don't believe any more and that there is deep cynicism that anything will change, even if they speak up, even if they are right and even if they are believed; even if it is the sort of analysis we saw yesterday, presented as it was by Sir Brian Langstaff; even then, they don't think things will change.

Dr Chidgey-Clark: There is a significant number of people, as the NHS staff survey shows year on year, who do not believe that their organisation will respond to the matters that they raise. It is really worrying for both patient safety and the wider issues that they are speaking up about. There is so much more to do.

What I find when I visit organisations is that there is a continuum. Matthew Taylor talked about a continuum of organisations that are performing better and those that are not. In the organisations that are performing better when it comes to their speaking-up culture, which is

often related to better ratings, better patient experience and outcomes, I find that they have a sense of absolute curiosity about the data and the stories that people are telling them, both staff as well as patients.

When you go to organisations where they are struggling much more, very often the focus is on other things. It is on the performance target or the finance target. The culture isn't given the same weight. I can go to board sessions and look at board papers. You get a sense: is culture last on the agenda? Often, after a committee has finished, they ask, "Any questions?" and they move on. That gives you a huge sense about the priority that an organisation is putting on its culture. All the while the centre is measuring performance and finance, which obviously is key, but there is the third part of that, which is the cultural metrics: "How are we listening? How are we listening to change? How are we taking these recommendations?" I agree with Miles that there are so many recommendations. There is currently work that my office is involved in with other patient safety leaders you have heard from in written evidence. They are working on streamlining recommendations, making them more evidence-based and more manageable for organisations.

Having been a non-exec director in an NHS organisation as well, and a nurse by background, I know what it is like for boards faced with a plethora of recommendations from all these reports, plus all the compliance issues. It can be too tempting to focus on just ticking the box and say, "We've done that," or, "We've dealt with it," but not really getting under the hood of whether behaviour has changed at the frontline. That is what needs to change. It needs to be a curious board.

Chair: That is what former Prime Minister, Theresa May, said yesterday in the House. In her opinion, too many people are watching their own back and not doing their job on behalf of the public. We are all constituency MPs around this table. We get casework. If we just tick the box and then put that casework on the Done pile, the constituent will very soon come back to us and say, "Well, that hasn't been done." I cannot understand why public servants, in the NHS or otherwise, think that they are different.

As we go through, and as other people are talking, have a think about where this has been shown to work well. Where do you think this kind of leadership is leading organisations at system level, trust level, DPH level or primary care network level? Have a think about where you think it is working well and where you have seen good leadership. As you do that, let's bring in Paul Blomfield.

Q61 **Paul Blomfield:** I want to pursue this theme a little further. Jayne, in your opening point—you repeated it a number of times—you talked about the way in which the culture of the NHS prevents progress in this area. The staff survey not only demonstrated their sense of fear and futility about speaking up, which we have talked about, but showed that those numbers have been getting slightly worse over the years. We are not even incrementally moving forwards. We are moving backwards.

In the survey, there is also the sense that staff who make mistakes are not necessarily treated fairly. There have been so many efforts to address this issue but no progress. What should we be doing? Following the Chair's points, where are the examples of good practice from which we can learn?

Dr Chidgey-Clark: That is a really important point. I will start with some examples of good practice and talk about organisations I have engaged with. I have been out on visits and seen how their leadership team, when we are walking around, is engaging with teams. They are known and visible. A key part of leadership is visibility, even to the point of being in a lift and saying, "Oh, I wanted to catch you"—they didn't know who I was; it wasn't a planned meeting—"I need to talk to you about X and Y." It is about approachability and that, "Yes. Hear you. Going to act." It is the visibility of the whole leadership team.

On the particular visit I am thinking about—I have seen other examples—what they showed me is that it starts with the tone from the top, but it is absolutely embedded at different levels through an organisation. If you go into a clinical area, the teams are talking about their safety huddles. They are talking about how they get together every day. They are talking about what it feels like today and is there something they need to raise, to escalate. They are feeling not unsafe to raise matters that are going to get in the way of patient safety or how it is going today.

If you look at their governance structures, their governance meetings, their appraisal systems or their one-to-ones, it is on everybody's lips. "What is it like here today? What are we doing? What do we need to do more of? How are we addressing that? Is there anything I need to know?" That is a very curious question for a leader: "What do I need to know? What do you need to tell me? What do I need to hear?" When we see that, we often see an organisation where the workforce feel valued.

I have a strong sense that there is a very strong correlation between organisations that have a better speaking-up culture and a better quality improvement culture. We need people who can speak about patient safety. Our workforce are our early warning and are absolutely vital for telling us what is going on. The frontline has the best ideas for a better way of doing it, a safer way of doing it and a less expensive way of doing it, which is more effective and efficient. If we clamp down on ideas because we do not have a culture where we value everyone's contribution, from the most junior to the more senior, we will not get the best out of our workforce. They are not going to feel valued. Most importantly, they are not going to tell us when there is something to really worry about. As a leader, that is what we need to be curious about.

There are better organisations. They are much better at putting it right through the system. It is not just having a board report twice a year that comes from data from the freedom to speak up guardian. It is so much more than that. It is layer upon layer. We have produced a self-reflection tool where we encourage boards to reflect on where they are in their

journey and to have an improvement plan. When you self-reflect, it is not just about leaders sitting and deciding in a dark room. The better organisations are engaging with their staff networks. They are looking at their staff survey results. They are doing pulse surveys. They are asking in team meetings. They are using a plethora of mechanisms to understand.

The workforce know what their barriers to speaking up are. If you give them safe spaces to talk about it, they will help you to look at the solutions for addressing it. Indeed, we have some organisations where 75% of the workforce feel that it is safe to speak up and that something is going to be done about it. We have others that are at the much lower end. We need to learn better, and quicker, from the best.

Q62 **Paul Blomfield:** What you are describing very comprehensively and very passionately is management theory that could apply to any organisation. The car industry actually looked at the benefits of empowering the workforce more than two decades ago. I think Nissan led on it, and it transformed the way that they ran their factory. It is pretty standard management theory and really important. Why are so many NHS leaders failing to embed it in their organisations?

Dr Chidgey-Clark: This is a complex situation. Are we recruiting leaders with the right values or the right skillset? Obviously, there were recommendations coming out of the Kark review. NHS leadership are looking at that competency framework, but it has not been embedded yet. We cannot expect people—not just new leaders but all—to necessarily have an understanding of what those requirements are and how to have difficult conversations. It is hard. I have sat on boards. It is hard to be curious when you have bad news or a challenging situation, but we see too much defensiveness. Are we giving them enough support, both from the centre and as we individually develop and support our managers and leaders, to know how to have those difficult conversations and to be brave? Very often, external scrutiny then says, "Well, you're wrong and that's wrong."

The blame culture is far too apparent. We all make mistakes. We are not born managers and leaders. We have to be appropriately developed and supported to be the best we can be. Sir Gordon Messenger talked very eloquently about that. There is much more we can do up front in training, development and support to make sure that we have the best.

Q63 **Paul Blomfield:** This is just a thought. Does anybody sit down each year, when the NHS staff survey figures are published, analyse them and think, "Hang on a minute, that trust is getting it profoundly different. Their numbers are so much better. What can we learn?"

Dr Chidgey-Clark: Absolutely. After last year's staff report, I wrote to those that were performing the highest, those that were the most improved and those that were the worst performing. For those that were the best, I said, "Can we come and learn what you're doing and what is

going to make a difference, so that we can do case studies and share that best practice?" It is important to have time to do that.

I heard Matthew Taylor talk about how he was surprised that leaders don't spend much time going to other organisations and finding out. We need more of that, but we cannot underestimate the huge pressures that our current NHS organisations are under, in capacity, performance and finance, so we need to allow people the time to do that. We should make it an expectation rather than its being a nice to have if you can find the time. Otherwise, how do we learn from the best?

Chair: That's brilliant. Thank you.

Q64 **Mrs Hamilton:** Good morning. My questions are for you, Dr Chidgey-Clark. I really enjoyed reading about the guardians that the NHS are trying to put in place. These people going in are supposed to be independent. They are supposed to be allowed to grow and develop within an organisation.

The problem that I have with what I have read is that all organisations are required to have them, but the implementation of the role varies greatly depending on where you are. It is quite inconsistent and doesn't meet national guideline standards. Can you explain why this is happening and why we are not able to recruit?

Dr Chidgey-Clark: Thank you very much. It is a really important area, and obviously one that is very close to my heart. When the freedom to speak up guardian office was set up, and this role was set up, in response to Sir Robert Francis's Speak Up review and the earlier review into Mid Staffs, the vision for the role was to be an additional safety route so that if people could not speak up through their line manager, or other routes within an organisation, they would be able to go to that independent and trusted person. That person would manage their cases and would make sure they got addressed. They would also act as an ambassador for cultural change in the organisation.

When the role was envisaged back in 2017—I have been in role since December 2021—as with many new roles in the NHS, there was a mandate through the NHS contract that "You should have this role and here is a universal job description for you to use." There was also freedom to adapt, with the recognition that different organisations would be at different points in their journey for the trust of their staff and the need for the guardian. There was some leeway in implementation.

Having said that, there was guidance that the role should have protected time. You do not give somebody a role on top of a really busy day job because how are they going to have time to do that? There was guidance about where it should report in the organisation. We have guidance that it should not be suggested that it should be an exec or a non-exec leader in the organisation because of the hierarchy. We know that hierarchy can be a big barrier to speaking up. What we suggest is that the role sits within the organisation and has direct access to the chief exec and chair.

We have a framework for how we see the role, but then it is down to individual organisations to decide how they want to implement the role, based on best practice.

What we see is absolute inconsistency, which is a big disappointment to me. We carried out a review of the 10 ambulance trusts in our Speak Up review that was published last year. In that, we saw far too many examples of trusts having minimal guardian hours or dedicated time to carry out the role. There were many big cultural issues. That is replicated when we do our annual survey of guardians to see the sort of way that their jobs are managed. We have some organisations that might have two full-time guardians and other organisations that have a very part-time guardian. That inconsistency is a worry.

Our office was not set up to be a regulator. We cannot dictate. However, we have best practice. What I rely on is NHS England and CQC as the regulators to help enforce. Indeed, there are recommendations now coming out of the new well-led domain of the CQC. They will speak to an organisation and make observations. Whether they have a guardian and whether they have enough time will affect their rating. The inconsistency is a big worry. I would like to see more consistency, going forward, and more support from the regulators to do that. I am working with them on that.

Q65 **Mrs Hamilton:** To follow on from that, I agree with you that the inconsistency is very worrying, to say the least. You really need these people out there, doing what they need to do, so this is my second question in that area. Do you believe, when we get the guardians in place, that they are getting enough support? It is so inconsistent and the role, although very clear, is not being carried through. There are national guidelines, but it does not seem to be a mandatory thing that an organisation has to do. Are those people getting enough support? Are there enough resources within the role to enable them to do the role properly and to be honest?

Dr Chidgey-Clark: The answer to that is that it is varied. In the better organisations it is a very well-resourced role that is held in an appropriate place in the organisation. The guardians I speak to who feel really well supported have direct access to the chair and the chief exec. They can go anywhere in the organisation. They have the time and the resource. Very often, they might have a network of guardian champions to help with the work that they are doing, both proactively and reactively. In other organisations there absolutely is not that support. Very worryingly, I have heard accounts from some guardians who feel that, when they are delivering messages around themes that are hard for organisations to hear, they suffer detriment themselves. That is clearly unacceptable.

Q66 **Mrs Hamilton:** My final point is this, as we have to round up quite quickly. I believe that if we are to improve leadership and standards, there are people that we really need to ensure we are implementing across the NHS. If there was something that you would like to see, as a

fellow nurse, to ensure that that role is in place and doing what it is meant to do, what would that be?

Dr Chidgey-Clark: What I would like to see is consistent implementation, according to the guidance. What I would like to see in relation to that as well is guardians having the protection—maybe a bit like internal audit often does in organisations—of being appointed and being stood down from their roles by the board rather than by an individual line manager to give that scrutiny. They should absolutely have protected time to carry out the role and to have access to the chief exec and the non-exec, and a non-exec and exec director lead for wider speak-up culture, which is obviously much more than just the guardian route.

Mrs Hamilton: Excellent. Thank you.

Q67 **Rachael Maskell:** Miles, perhaps I could turn to you. Obviously, holding the system to account is part of this process. We have talked about different mechanisms that are not working accordingly. Are we measuring the wrong outcomes when we look at that with regard to patient safety and what is happening in the clinical environment? If we are, what should we be looking at or measuring in order to ensure that we get positive outcomes and responsiveness from the system, as opposed to the defensive culture which clearly we often see?

Miles Sibley: There are a couple of points. One is about outcome measurements and one is about culture. I will take each in turn.

Yes, I think that to some extent we are measuring the wrong outcomes. Looking at the fixed mechanisms for understanding patient experience and hearing the patient voice, we have the friends and family test. We have a whole series of national patient surveys—maternity, adult in-patients, accident and emergency and so on. Then there is the complaints system. Those are the main mechanisms. They all have their own measures and all the rest of it.

The interesting thing about the friends and family test and the national patient surveys is that, for a start, they are not particularly patient-centred. They are more provider-centred. It is providers saying to patients, "Tell us how we're doing. Tell us about our services. Tell us about things like waiting times, cleanliness and all the rest of it." It is all good and important stuff, but it doesn't allow patients to say what matters to them. In the case of the patient surveys, they are channelled through fixed questionnaires where the questions have already been determined for them. On top of that you have the fact that with the national patient surveys, the findings from them, the results, are fed back to providers typically six months or more after the initial fieldwork started, so they are always retrospective. In a sense, they are always out of date.

There was a piece of research that was done on complaints data. There was a paper in the *Journal of the Royal Society of Medicine* in 2022 that talked to complaints handlers about how they were reporting their

complaints data. They used something called the KO41a. I don't know why it is called that, but that is the name of the official complaints data reporting. Some complaints managers felt that it was quite an inappropriate way of collecting and reporting data. One of them even went so far as to describe it as supplying false information because of the way that complaints, which can be quite complex and wide-ranging, have to be categorised within fixed categories. How good is that for learning? Some of the complaints handlers thought that it was not. Yes, to some extent the outcome measures are not necessarily completely wrong, but they are not as wide-ranging, comprehensive or as flexible as perhaps they need to be.

The second question is about culture. Our understanding of culture in the NHS organisation and professional cultures is often not very good. All the inquiry reports over the years, from Mid Staffs onwards, very often talk about problems with the culture of organisations. They often talk about culture as a singular thing, and they often do not really say what culture actually is. We have all heard the saying that culture is just the way we do things around here, but that is a hopelessly vague way of describing it. It does not help people understand what it is.

We did a piece of work for the CQC about a year ago, where we went back through 10 years of official inquiry reports. We looked at 19 separate reports. We did not look at the recommendations coming out of those reports. What we looked at was the detail of the evidence that had been uncovered by those inquiries in respect of professional and organisational cultures and how those go wrong. The hook for that was Bill Kirkup's report on East Kent, which was called "Reading the signals", where there is something really important about not necessarily waiting for inquiry recommendations and not necessarily looking at outcome measures, but learning day to day in your practice and in your management of a service to read the signals as things start to go wrong.

We did a big thematic analysis across 10 years of avoidable harm inquiry reports, looking specifically at culture. We identified six different types of culture: reporting culture; compliance culture; caring culture; teamwork culture; accountability culture; and learning culture. We pulled out masses of references to those, looking at what is known to have gone wrong with those sorts of things and also looking at the different states in which those cultures can exist, those being complacency, avoidance and denial. From that we built a framework, which we have given to the CQC, which can help people to get a much better and much more forensic understanding of what types of professional and organisational cultures exist in healthcare and how they can move between the different states of complacency, avoidance and denial, with examples taken from the inquiry reports.

There was a reference to management theory. What we were looking at was not theory but what is known to have actually happened time and again in different places. What you see is what Bill Kirkup refers to as

patterns of behaviour. You can start to see the way in which, for example, at Gosport complacency was characterised by case notes not being filled out sometimes for entire days. Management and ward managers seemed to be okay with that.

With avoidance, there is the case of Ian Paterson, the breast surgeon who is now in jail. His colleagues described him as "a unique rogue. I knew he was up to something, but I didn't really want to have to tackle it". When you get into denial, that is when you see examples of things like case notes being lost and active cover-up, as at Morecambe Bay, when midwives colluded over the accounts of care they would give to investigators.

It is absolutely possible to get beyond the wishy-washy notion of culture being the way we do things around here to a much more forensic understanding. For me, personally, if we can put that in the hands of health service managers, health professionals, ward staff and so on, and of course the people dealing with the patient and staff voice, who are also sometimes not quite sure, with vague worries that something is not quite right, I think we can give people much better tools to tackle these things and to do what Bill Kirkup described as reading the signals and get there before you end up in the inquiry, the recommendations and all of that.

Q68 **Rachael Maskell:** Jayne, I want to ask you, in addition, to reflect on this. Obviously, we have a litigation culture as well which is driving much of the protectionism of organisations. There is also huge inequality of power, whether it is a member of staff, a patient or a carer in the system. How can we equalise to enable a co-production of outcome, as opposed to what we have at the moment, which is a very authoritarian approach to complaint handling?

Dr Chidgey-Clark: That power differential is absolutely huge. We see it played out far too often in those high-profile cases. Taking another C from your cultures is the culture of curiosity. Coming back to the Chair's comments about where we see the best, it is the organisations that have a culture of curiosity and are therefore listening, looking and examining their data deeply. That is data coming through all sorts of routes: the patient experience data; the patient outcome data; the patient safety data; the safeguarding data; and HR, bullying and harassment, alongside the data coming through the freedom to speak up. If you have that culture of curiosity, where we want to see it and want to know the good, the bad and the ugly, we can address it.

On the culture of complacency—"I don't want to know." "It's in the too difficult pile." I only want to hear what's good"—there are organisations that we talk to that are not afraid of having uncomfortable conversations. There are others that we call comfort-seeking. "Oh, we don't have many numbers of freedom to speak up cases. That's a good thing." "Well, there's nothing precise about what's a good number. "We don't have that many Datix." "We don't have many patient safety reports." I once worked in an organisation where, as a nurse, I was told, "It's really good. We

don't have many patient safety reports here." I was thinking, "What? Are we not reporting near misses?" We make mistakes, but if we have a blame culture and not a culture of curiosity, we are not going to have that.

The power differential is very important to bear in mind. The best organisations are co-creating. They are doing it through the work I described earlier and through multiple levels of engaging with the workforce to understand what is going to make it different. Clearly, there will always be hierarchy and power. We must move away from the defensive culture to a more open culture, admitting our mistakes. We have been talking for a number of years in the NHS about a just learning culture, but we do not always see good evidence of it. We often look for blame of an individual rather than no blame, as we see in other safety industries where, as long as it was not a deliberate error, a human error is not blamed. It is, "What can we learn from it and we will take that gift of learning?"

Chair: Thank you. Very briefly, we will move to Caroline Johnson before the next session.

Q69 **Dr Johnson:** I have two questions. Why do you think inquiries take so long, compared with international comparators? That gives people an opportunity to say, "That was ages ago. Things have changed since then." Therefore, they don't look more closely. What can we do to make these things quicker and more efficient?

Dr Chidgey-Clark: That is probably an area out of my remit. Sometimes the decision to carry out an inquiry will take too long. Sometimes we have quick decisions to have an inquiry.

The defensive culture can get in the way of people giving evidence in a meaningful time, but sometimes it is just human business. We know the extreme pressure that the NHS is under, if we are talking about NHS inquiries, and therefore that can impede. They take far too long. Looking back over the blood scandal, I was reading Sir Brian Langstaff's report last night with deep dismay. There will be potential to say, "Oh, but that was back then." But for the messages to the health service now around leadership and accountability, that message is for today because we are seeing it time and time again.

We need to have timely investigations by expert investigators who are trained in investigations. Far too often, investigations are done as an add-on to their day job by people who have not had the necessary training. That is safety for the science of investigation. We need a timely call for inquiries and investigations and, going back to your phrase, Ms Maskell, co-creation. As a workforce in the NHS, we understand the importance of learning. If we see the actions coming through quicker, that will certainly help.

Q70 **Dr Johnson:** Do you have anything particular to say on this? Sometimes

we listen to every single story. There are reasons why you would want to listen to every single story rather than a representative number of them, but it makes lessons take longer to learn. What would be the Patient Experience view of that?

Miles Sibley: The point about listening to every single story is necessary. People are hurt and harmed terribly. If you look at things like pelvic mesh, there are life-changing injuries. If you look at deaths in maternity, people lose their baby and then encounter the further harms of cover-up and denial. People need to get their stories out. The NHS is a healing organisation. Being heard is part of healing after harm. I think people need to have ways to be heard.

On delays, I cannot talk for inquiry processes, but on the time it takes for these things to come to inquiry, partly it is because of those cultures of complacency, avoidance, denial and cover-up. Foot dragging is a tactic. When you read inquiry reports, you see examples of that all the way through. Again, there are things like case notes being mysteriously lost. It is a tactic. You can go right to the start, when people start to raise concerns and find that they are hitting a brick wall almost straightaway. A term that is commonly used across healthcare when talking about patient voice and patient experience is "anecdotal evidence". When people talk about patients' stories being anecdotal evidence, that is a shorthand for saying they are subjective, emotional, irrational, unreliable and basically should not be given too much credence. It starts there.

The term anecdotal evidence is not just dismissive, it is contemptuous of people's experience. I, personally, would like to see it never mentioned again in healthcare. It starts there, and that is where the delays come through. There is research being done. Healthwatch England did a report some years ago called "Suffering in Silence". It has been confirmed by other studies since. It was about muddled routes for finding your way through the complaints system. Is it PALS? Is it complaints? Is it Healthwatch? Where do I go? People are having to navigate their way through, meeting dismissive attitudes on the way. Then, when it all starts to get really serious, they encounter denial and obstruction. It happens to regulators as well. When the CQC went into East Kent—this is revealed in Kirkup's report on East Kent—they were met with an aggressively hostile response. CQC investigators were forced to sit in a corridor and wait for 45 minutes after the supposed start time of their meeting, as a tactic.

As I say, I don't know about the processes and the complexities of the inquiries themselves, but what we see time and again is patients and harmed families sometimes having to speak up for years before finally being heard. I will finish with a quote from Baroness Cumberlege in the medical devices safety review about all the terrible harms from Primodos, sodium valproate and pelvic mesh. She said that the patient experience "must no longer be considered anecdotal and weighted least in the hierarchy of evidence-based medicine". That is something that the whole of the NHS needs to hear and act on.

Q71 **Dr Johnson:** That is very interesting. My other question was about the culture. We often hear about comparisons with industry, particularly aviation and other travel industries. Does recruiting NHS managers from within the organisations of the NHS not perpetuate the same culture? You see people who go and work for one business, and then another business in a different field. They move around the private sector. NHS managers tend to be recruited from within. Many of them have previously been clinicians. Does that not perpetuate the culture? What could we do to get managers in from other cultures?

Dr Chidgey-Clark: That is a really interesting point because it is about having diversity of talent. Indeed, Sir Gordon Messenger talked about the talent pipeline and how we nurture our leaders. There needs to be a mix. Recruiting just because someone has come from a different industry is probably not a good idea because you need people with experience. What I am trying to say is that you need a mix of management and leaders.

Q72 **Dr Johnson:** We don't have that, do we, particularly in the more middle and junior ranks? If I think of the managers that I have worked with, they have mostly been people who used to be senior nurses on the wards that I worked on. They are now supervising. If they are good that's great, but if it is a poor culture you have a continuation of the same culture within the management structure because it is the same people.

Dr Chidgey-Clark: I would say that is the same across any sector. Often you want specialists who understand the business within which they are working. It comes back to the leadership and management training that we are giving. If we take nursing as an example, we quite often promote people to a leadership position with very little preparation for that. There is an expectation that, just because you are more senior, it makes you a good manager. Of course, we know that is not true. If you have a great learning experience and you have great role models throughout your organisation, you will develop those cultures, but not if they are poor. There is something about how we train and support our managers.

I wanted to ask, Chair, if I could offer to share some further information around training and support, and particularly on the item that—

Chair: That would be great. It's not uncommon for witnesses to write further to their evidence.

Q73 **Dr Johnson:** When you are appointing managers, you have a balance. You have someone who is great at management but does not have clinical experience of the area they are working in, or even clinical experience at all. You then have other people who may apply with lots of clinical experience, knowledge and skills in the area they would be working in but not necessarily, as you say, the management training experience. If you are appointing a manager, is it more important that they have the clinical experience or the managerial skills?

Dr Chidgey-Clark: It depends on the role that you are appointing them to, and what you need in the skillset. There are some clinicians who are

excellent managers. There are some managers who do not come from a clinical background who are excellent managers. I think we need a better focus on how we prepare and support our managers, whatever background they come from.

Chair: Thank you very much, Miles Sibley and Dr Chidgey-Clark, for giving us your evidence.

Examination of witnesses

Witnesses: Dame Linda Pollard, Professor Hawthorne and Sam Allen.

Chair: This is the second panel of the latest part of our inquiry into NHS leadership. In the room we have Professor Kamila Hawthorne, who I am sure is well-known to viewers as chair of the Royal College of General Practitioners. We have Sam Allen, chief executive of the North East and North Cumbria integrated care board, who we can hear but cannot currently see. I have no doubt that will correct itself. We have Dame Linda Pollard, who is chair of the Leeds Teaching Hospitals NHS trust.

Q74 **James Morris:** Obviously, there are a lot of management and cultural challenges within the NHS. Starting with you, Professor Hawthorne, do you think that the performance management regime and emphasis on top-down targets, and that culture, is partly to blame for negative culture within the NHS?

Professor Hawthorne: That feels slightly like a leading question to me. Certainly, in general practice, we are very much affected by targets, particularly access targets, as I am sure that everybody in the room will know. Of course, when you have a finite working capacity, the more pressure you put on targets, the less availability you have for continuity of care, which, of course, affects patient safety. If we are talking about prevention of incidents, there is definitely a real pressure. We see it in secondary care as well from our primary care vantage, but it is definitely happening to us in primary care. We know from our tracking surveys that about 46% of members who responded to our surveys said that they do not feel they have enough time to manage patients adequately and safely in their consultations because of the pressure.

Q75 **James Morris:** Sam Allen, as chief executive of North East and North Cumbria, what is your reflection on the pressure placed by performance management expectation in the NHS on your ability to manage other issues and to develop a culture of curiosity and learning, very much like we were exploring in our first session this morning?

Sam Allen: Thank you very much. Many apologies. My video doesn't seem to be coming up.

We would certainly expect there to be pressure on performance. We are a national health service. The public expect and require standards to be met, wherever you are working in the NHS. In terms of a learning culture, it has been a priority for us in North East and North Cumbria to

set up what we call our learning and improvement system, which has been very focused on learning as our engine for improvement. As regards learning from others, we have tried to foster a culture whereby we are curious, never have the attitude that it could not happen here and are openly learning from others, not just across the NHS but globally. Through our learning and improvement community, we have connected with other organisations globally because we want to learn from the best.

The cultural side is the real focus. It has to be. We are a people-based organisation. If we are thinking about management and leadership, culture is created by the people who work in the organisation, so it needs to be purposeful. We need to focus on learning and improvement with real intent. It is not an "either/or"; it is an "and and". Of course, if your focus is on improvement, performance is at the heart of it.

Q76 **James Morris:** As a follow-up question, what I am trying to get at is this. Over time, the NHS as an organisation has become very good at examining the problem. We spend sessions like this examining the problem, but the solutions are difficult to find. Does the hierarchical nature of the NHS system, where managers are expected to comply with performance management and are constantly looking upwards, have a negative managerial effect?

Sam Allen: If you are always looking in the rear-view mirror, you certainly have less time to think about the future and look forward. I am a manager in the NHS myself. I would say that sometimes we have a propensity to focus on the planning. In fact, if we focused far more on the delivery of things, perhaps we would see different results.

Part of that, of course, is the very context and environment within which we work. It is highly political. We are on short-term planning cycles. It is difficult to plan for the long term, particularly with security around the resources that you have available. The environmental context within which we operate is wholly important in the NHS. It is not as simple as saying, "If we spent more time just focused on the delivery, we would get those results." We really have to think about the context within which we are asking NHS managers to operate.

Q77 **James Morris:** Dame Linda Pollard, what are your reflections on the tension that exists within the system, which can have what may be unintended, but quite negative consequences? What is your perspective?

Dame Linda Pollard: I am chair of Leeds Teaching Hospitals, so I will try to wear that hat. Of course, I am also the co-author of the Messenger review. Gordon has stepped back, and I am still heavily involved with it. That is just for information.

I agree with Sam—absolutely. It goes back to what we found during our six months. Gordon, the team and I talked to about 3,000 people, probably, about exactly what would be critical here: how do we stop looking in the rear-view mirror, as Sam said, and focus internally? By the

way, I am very private sector. I don't come from the NHS. I am not a medic. As chair of several health organisations over my career, I think that it has to go back to the culture. That is an easy word to say, but it is about how you engage, communicate and are visible. It is about the transparency that organisations have.

There are 22,000 people here at Leeds, in my trust, over seven sites, so it is quite hard to touch. I will revert to that, away from the national picture. We were in dire straits 12 years ago. We had a massive deficit—as I have said, probably one of the worst that I have seen in any sector I have worked in. I am not blowing my own trumpet, and I hope Sam would agree that we are one of the top three in the country now, and we are very big and very complex.

You have to stop looking in the rear-view mirror, because it is a cultural thing that you develop. The Toyota method is a management tool. I was trained in it at BMW many years ago. We have that here at Leeds. We have been working on it for a long time. We need that right through the system. You must stop looking in the rear-view mirror, so that people will trust you to engage and get the staff in the right place. At the end of the day, it is about patient delivery and getting the right service in the right place at the right time. Do we share? We are dreadful at it, mostly because, as Sam very eloquently said, there is too much looking in the rear-view mirror and not enough saying, "Just leave us alone. You've got to trust us to get on with this."

It leads me very much back to the recommendations in the Messenger review. Unfortunately, not everybody is in the position that, for instance, Leeds is at the moment. There is a handful of us—absolutely—at delivery level, whether we are talking about mental health, community providers or even ambulance services. Social care is missing there as well.

James Morris: Thanks for that. There is much more that I could explore, but we should probably move on.

Chair: There is always more, Mr Morris. That is the nature of our lives. Thank you very much for that.

Q78 **Paul Bristow:** Professor Hawthorne, are GPs always the right people to manage GP surgeries? Quite often, they can become big centres, serving 30,000 or 40,000 people in the case of Peterborough. Do they always have the right skillset? Are they always the right people to manage these mini-hospitals, in effect?

Professor Hawthorne: In fact, there are even bigger federations of GPs that have 100,000 patients in them. Most practices have a practice manager, who is employed by the GPs to manage the practice. The strategic direction of the practice—the leadership, I suppose—which is different, of course, is usually done by the GP partners who own the business. It seems only right that they should do so.

You are going to ask me, "What training do they have in leadership and management?" Many medical schools nowadays include a vertical theme in leadership and management, which is generic. During the GP training scheme, which is a three-year-long scheme, there are opportunities to learn leadership and management, but not nearly enough. It is a very condensed programme. Many GPs need much more training. It is available, but it is about having the opportunities to get that training.

Q79 **Paul Bristow:** In my experience as a constituency MP, I see enormous variety. I see GPs who are natural entrepreneurs and are running centres and bigger practices very effectively. I also see people who are probably brilliant GPs but don't have the skillsets to employ staff, manage systems and think of processes that would enable patients to have better throughflow. It is a complicated thing. They are brilliant GPs—brilliant medical professionals—but this was not really what they signed up to do.

Professor Hawthorne: It is not what they were trained to do. We are not trained to be experts in managing HR processes, for example. Many of us have learnt on the job. I certainly have. However, nowadays it is possible to have that training, which is why we are very keen as a college to push the new to practice fellowships that are currently being closed down across England by NHS England. These are fellowships that allow newly qualified GPs to spend two years in a salaried position in one place, where they can really get stuck in, learn how practices work and how they should be led and managed—how the finances and the HR work—and have some time to develop themselves professionally, before they go on to other practices.

We have evidence on how effective those are. Many of them show us that these GPs are then taking on PCN and higher leadership roles. One of the problems that we have in the NHS is that there are not enough GPs in leadership positions in the NHS executive and the higher levels of the NHS.

Q80 **Paul Bristow:** In your mind, do we have the right model in general practice? In effect, they are mini-businesses, but it's not like they can go bust. They can go bust, but there is always going to be a demand for their services. In that regard, do we have the right model when, effectively, we can be allowing patients to be seen by people who are just not up to the job a lot of the time—in terms of managing the practice, not as a GP?

Professor Hawthorne: Perhaps you ought to retract some of that. They are up to the job.

Q81 **Paul Bristow:** No, I won't.

Professor Hawthorne: They are working well as GPs.

Q82 **Paul Bristow:** I don't think so.

Professor Hawthorne: We are finding that some practices are going to the wall. They are going to the wall because financially they are not able to cope and they do not have enough GPs to run the practice properly. I don't really accept what you are saying—that some GP practices are not worth the money that they are receiving to do the job properly. They are doing the job properly. We have quite stringent regulation to pick up those practices, and there will be a few, that are not.

Q83 **Paul Bristow:** I'm not going to retract what I said because I think it is very fair comment to say that, if you have tens of thousands of GPs at practices across the country, some are not going to be fit for purpose. A lot of that cannot be blamed just on money.

Professor Hawthorne: There will be a few. From CQC's regulation, that number is very small. It is less than 5%.

Q84 **Paul Bristow:** Five per cent. is still a significant number.

Can I go to Sam Allen? I want to talk a bit about patient representation within leadership and patient feedback to leaders in our NHS. Do you think that the patient voice is being heard appropriately by leaders in the NHS?

Sam Allen: We have many mechanisms by which the patient voice is there. For example, Healthwatch is a member of the integrated care board. We have our community and voluntary sector organisations represented. We also have a patient voice committee in the integrated care board, where we always seek to triangulate views. We have some good examples of that. We also have really good examples across the NHS of patients as leaders. There are patients in formal, paid leadership positions as well.

In terms of the focus of your inquiry, there is equally ample evidence of where it has not been heard. From a management and leadership perspective, having an approach that is very centred on patients and deploys different approaches in order to be able to hear what people are saying and get alongside people is something that is subject to ongoing improvement, particularly working with representative patient groups. For us in the integrated care board, it is about working with our local authority partners, through their democratic links, to hear the voices of our communities. That is absolutely fundamental. We have some good evidence of some good models, but there is certainly more that we need to do, particularly when it comes to safety, and listening, in order to take preventive steps and actions to reduce risk and keep our patients safe.

Q85 **Paul Bristow:** Do you feel that Healthwatch is an effective organisation in ensuring that the myriad patient experience and patient views are heard? Is it the case that there are appropriate systems and structures in place to enable Healthwatch to be heard?

Sam Allen: I can speak from our experience. In North East and North Cumbria, we have 12 Healthwatch organisations. We fund and work with

them in a way that enables them to be representative across the integrated care board. My view is that they do very well with the resources that they have available. They are in touch with the key issues that our communities are raising—the sorts of things you will be very familiar with, such as dentistry access. However, their resources are limited, particularly for patient groups and representative groups, given their charitable status. Obviously, we work with all of the groups, but the structure is challenging. There is not really one body anywhere, among all of the bodies and organisations, that can speak with one voice. What we need to do is to make sure that we have mechanisms in place across the integrated care board whereby we listen to a variety of views and different parts of our communities.

Q86 **Paul Bristow:** Dame Linda Pollard, do you have anything to add on the two questions that I asked previously?

Dame Linda Pollard: Yes. At the end of the day, all of us should do this. It is an easy thing to say, but a more difficult thing to do, particularly when we get complex organisations. Basically, the patient voice should be at the centre of what we are doing. It is all about delivery. It is about how it is owned within the organisations. It is not just a nice thing to do, a nice thing to say or a tick-box exercise. It comes back to governance. In well-organised organisations, it is owned by a variety of different voices within a governance structure. That comes through at committee level. Clearly, there are more responsible people around the board—the medical director and the chief nurse, in particular—but we are always synched together. It is about getting out. It is about what I have touched on before—feeling the front of an organisation, by all of us. We all have that responsibility. When I say well led, it is not just people sitting around the board; it is senior managers throughout the organisation.

Then you have the whole process of how you engage with that. That can be internal, going through committees and feeding up to the board. It can be patients coming in and telling their stories at the board, which should happen every single time. It can be patients' stories at committees and people getting into those committees. Whether the news is good, bad or awful, we have to hear it, through complaints procedures, the national guardian and the ambassadors who feed the national guardian in organisations.

There is a delivery missing that involves us all, between the health and wellbeing boards at place level. We are all in that together. Patients and the third sector—the charity sector—are in there. I co-chair ours in Leeds, across the whole city, with the local authority. It is really important, because in that way we touch everything, whether it sits in primary care or in some other part of the system.

At place level, there is an awful lot that we could do to join up a lot more in the whole structure of the NHS. With every respect to the ICBs, which oversee what we are all doing, we have a responsibility at place level to get organised between ourselves and to deliver patient comment and

voice. I would put staff in that as well, because staff are key points in understanding where it is going wrong. Without doubt, things will go wrong in this big, complex organisation we are all involved in, but we need to know, we need to learn and we need to share. That brings me back to the things in the Messenger report.

Chair: Brilliant. We have about eight minutes left.

Q87 **Rachael Maskell:** Dame Linda, can I start with you? Patient complaints often become very systemised very quickly. I reflect on a constituent who spent 10 years in the complaints system, where the resolve really should have been a quick admission by the trust, and reflection and engagement. How do we change the culture to ensure that we rapidly respond to actioning the complaint, as opposed to dealing with the complaint?

Dame Linda Pollard: I totally agree. Parts of it are terrible. I started my very first post as an independent adviser on complaints, interestingly enough, so this is a bit of a passion of mine. It goes back to culture. We get data that comes through our system. I know that a lot of other trusts do, too, so I think that I can speak on their behalf as well. Data is one thing; it is how we deal with it and the granularity with which we look at it. I put a huge onus of responsibility on my committee chairs, and regularly meet them separately to find out, and I observe, by the way.

We have to get into the complaints system a lot more. I am a bit fanatical about it. It sits with the chief nurse. I have the longevity data that comes through. If there is a batch of what I would call outliers that are taking far too long, your committee and governance structure should point it out. There may be very valid reasons for some of it, by the way. It is not always just what you see on a piece of paper or on a screen. It is about how we deal with it internally. That is completely unacceptable, as far as I am concerned.

It comes back to how all of us share the best practice that is in the whole system. We are not very good at it, regardless of whether it is complaints or anything else. We all know where the good is. It is just the plethora of things that the management—the system—throw at us and that we have to cope with. This should not be a tick-box exercise. This is learning. This is how we all improve what we deliver at the front door, to everybody. That includes every one of us in this meeting. There is definitely room for improvement. It should not be a tick-box. This is the first time that I have heard of it taking 10 years. That is absolutely dreadful.

Q88 **Rachael Maskell:** Sam Allen, perhaps I can turn to you, as a system leader. We have heard a lot of evidence today about the importance of culture change. As a system leader, how do you bring about that culture change to ensure that the accountability systems in the system are right and that you are driving forward the culture of curiosity that we heard about earlier, to ensure that we are looking to bring about change?

Sam Allen: It is very much a culture of collaboration. Of course, with the foundation trust regime, we have seen a good 15 years-plus of a highly competitive environment, particularly in healthcare. While competition is not always a bad thing, in the context of improvement and culture, we need a leadership mindset that is far more about collaboration, co-operation and working in partnership.

From an accountability perspective, using the operating model, ICBs certainly have a role, working with NHS England as the regulator, and across all of the services that we commission. That is not just NHS trusts. It is primary care services and community and voluntary sector services. We operate an approach whereby we utilise the data and insights that we have and focus on the key issues. That is very much from a perspective of leadership and culture. It also means looking at performance data, and how particular contracts and organisations are performing. Of course, the developmental side needs to be done together. There is no one part of our complex health and care landscape that can exist in a way that delivers outstanding services on its own. They are all co-dependent.

From a system perspective, we have convening powers to bring people together. As I said, we focused on setting up what we call our learning and improvement community. We now have 7,500 members of that community. It includes members of the public as well. We are doing not just leadership development, but communities of practice. We have communities of practice around leadership and safe transfers of care. Our latest community practice is on housing and care.

We are trying to foster a culture where everybody's strengths, experience and wisdom are valid and recognised. It is non-hierarchical. We are open and transparent. We spot where things are working well. Fundamentally, we are trying to shape and encourage a culture of peer review, where teams and different organisations in the system go to visit each other. One of the most enlightening parts of that has been in the areas of our system that I would say have the greatest opportunity for improvement. Some might describe them as areas with performance issues, but I would always say that they are areas with the greatest opportunity for improvement. We have matched or buddied them with bits of the system that are working well. Actually, both parties take something out of those encounters. There is learning in this for everybody. It is something that requires a deep commitment. It requires resources and prioritisation, and it takes time.

I want to conclude by saying—

Q89 **Rachael Maskell:** I am going to have to stop you there, because we are running out of time and I would like to put one last question to Professor Kamila Hawthorne. What do you see as the role of professional bodies and colleges in bringing about culture change? In a couple of sentences, can you say how you can bring about that culture change?

Professor Hawthorne: Our charitable object is to foster and maintain the highest possible standards in British general practice. In this particular area, we are doing it by putting out a patient safety toolkit. It has been out since 2017 on our website, freely available to our 55,000 members. It contains things such as prescribing safety, patient safety questionnaires, safety checklists for general practices and significant event audits. We have an RCGP leadership capabilities framework, which is very avidly taken up by members, together with a mentorship scheme to enable people to grow and develop, and develop the right cultures. As you say, culture is right at the bottom of all of this.

Q90 **Chair:** Brilliantly done. Kamila, I didn't get to ask you a question because we went straight to James Morris. I cannot let you go without asking you about the Prime Minister's speech on benefits and welfare—the sick note culture speech, as it was described. He said, "We're…going to test shifting the responsibility for assessment from GPs and giving it to specialist work and health professionals." My understanding is that GPs have said for years that they are keen to allow appropriately trained others to help in this regard. Has the speech been seen by the profession as saying, "We're taking this away from naughty GPs"?

Professor Hawthorne: I think that it was the words that were used: "We are going to strip GPs of the ability to write fit notes." It was the way in which it was said. I have had a conversation with Helen Whateley since, which was much more emollient. We are still not sure of the details, but that is helping us to see ways in which, when we have given a fit note to a patient who we think would benefit from seeing a work well consultant, we can refer them to somebody who has more time, and expertise in occupational health and so on, to be able to help the patient back into work.

Q91 **Chair:** Were you, as a royal college, involved in the conversations before that speech was given?

Professor Hawthorne: No. We weren't involved at all.

Q92 **Chair:** Capacity is always the challenge. You have talked about this with some of my colleagues today. Anything that helps you with capacity, workload and being able to focus on the key patients is surely a good thing.

Professor Hawthorne: We are happy with that.

Q93 **Chair:** I am just wondering who is the other workforce that is going to be these health professionals.

Professor Hawthorne: We are not quite sure yet who they are going to be, how they will be trained, how they will be employed and who will employ them. At the end of the day, our concern is the patient. We want what is best for the patient.

Q94 **Chair:** To clarify, you referred to the NHS England fellowship scheme,

didn't you?

Professor Hawthorne: Yes.

Q95 **Chair:** You said that they are getting rid of it. Those were your words.

Professor Hawthorne: This is the new to practice fellowship scheme.

Chair: Yes.

Professor Hawthorne: It has been running for two years. We heard in January that it was terminating at the end of March.

Chair: Okay.

Professor Hawthorne: It is finishing. Apparently, the moneys have been devolved to ICBs, but it is not ring-fenced money. We fear that it is going down a deep black hole and we won't see it again.

Q96 **Chair:** Same old. To be clear, when we make recommendations, you would be interested—

Professor Hawthorne: We would love to work with you on that and give you more detail.

Q97 **Chair:** Let's see if we can probe that.

Professor Hawthorne: Yes, please. We have good evidence that they are very successful in keeping people in position and stopping them going to Canada and Australia.

Chair: That is what this inquiry is about: good leadership at all levels, from primary care networks right the way up to Amanda Pritchard herself, running NHS England.

Excellent. Sam, we may not be able to see you, but we can hear you. You could be in Hawaii, for all we know, but no matter. I suspect that you are in North Cumbria, but never mind. What you said was excellent, and we heard you. The same applies to you, Dame Linda, and to Professor Hawthorne, who is in the room. Thank you very much. We are checking out and signing off.