Tuesday, 10 December 2024

(10.00 am)

LADY JUSTICE THIRLWALL: Ms Langdale.

MS LANGDALE: My Lady, may I call Sir Robert Behrens, please.

LADY JUSTICE THIRLWALL: Sir Robert, please come forward.

SIR ROBERT BEHRENS (sworn)

Questions by MS LANGDALE

LADY JUSTICE THIRLWALL: Thank you, do sit down.

MS LANGDALE: Sir Robert, you provided the Inquiry with a statement dated 3 March 2024.

Can you confirm the contents are true and accurate as far as you are concerned?

A. Absolutely. Yes.

Q. We know of course that you were the Parliamentary and Health Service Ombudsman between April 2017 and March 2024 and in that context, we invited you to provide a statement to the Inquiry.

Do you have it in front of you, your statement?

A. I do, yes.

Q. Can you tell us, please, first of all, a brief outline of the role and responsibilities of the Parliamentary and Health Service Ombudsman?

A. Yes.

Q. You do that at page 2 of your statement.

A. Well, the Parliamentary Ombudsman was set up under legislation in 1967 and the health element was subsequently added to it with the key issue of clinical judgment in health matters being added in 1996.

So the Ombudsman is a Crown appointment, reporting to Parliament, not to ministers, and that is a significant feature in the activities of the Ombudsman.

So the responsibility of the Ombudsman is not to be the champion of complainants, but to be impartial between complainants and bodies with jurisdiction that are defined in legislation and the key test under legislation is the test of whether or not there has been maladministration, which is a legal term but not defined in law.

So it's been up to successive Ombudsman leaders to define what constitutes maladministration and in the context of health it is about poor service, avoidable death and so on.

The office is probably the largest public service Ombudsman in Europe. It has 600 staff, based in Manchester and in London.

It has a responsibility to report to Parliament on an annual basis, both through a written report and

through an annual hearing through the Public Administration and Constitutional Affairs Committee.

Q. Which you attend, do you?

A. Absolutely. Yes.

Q. Or did attend, I should say?

A. I had seven experiences of that. And there is a lot of accountability. First of all, there is a unitary board which consists of Executives and Non-Executives to whom the Ombudsman must give an account. The National Audit Office sits on the Audit Committee of the Ombudsman. There are internal auditors and in my time, I introduced the idea of independent peer review of the office, so that Ombuds leaders in other countries would come to the office, review the evidence and give constructive feedback on how the office is doing and how it could do better.

Q. In terms of your European counterparts, how do the powers the Ombudsman has here compare with your European counterparts; what are your powers, I suppose, is the first question?

A. Yes. I did, with the International Ombudsman Institute in 2021, and I think it's included in the documents, a research study of 58 national and sub national Ombudsman schemes around the world. There are 150 national schemes around the world and the

International Ombudsman Institute is the core key body for Ombudsman leaders.

And what we discovered was that although the UK Ombudsman is the largest, in terms of powers, the Ombudsman is one of the weaker ones.

So most Ombuds schemes do not have the power of binding recommendations. Only in a small number of cases -- in South Africa, where there's been a lot of problems with what they call the Public Protector, and in one or two other cases does the Ombudsman have binding powers.

So in the UK, the Ombudsman can only make recommendations, she or he cannot enforce decisions and the only way of ensuring that decisions are implemented with reluctant bodies in jurisdiction is either by publicity, because they don't want to be embarrassed, or by being held to account by Parliament so the Ombudsman has the responsibility of reporting non-compliance to Parliament as well as other thematic reports. So that's one interesting point.

The Ombudsman does have the powers of the High Court to call for papers and to require co-operation and, broadly speaking, that works well. But the significant weaknesses are that first of all there is no public service Ombudsman scheme in the UK in

the way that there is in other countries.

Across Europe you will have one Ombudsman scheme which deals with public service and health complaints.

In the UK, you have 16 or 20 public service Ombudsman under different names because governments of all parties have failed to integrate the Ombudsman scheme, so that you have a Prisons Ombudsman, you have a Higher Education Ombudsman, you have a Local Government and Social Care Ombudsman, and so on and so forth.

The cost of that is that people don't know where to go when they have a complaint that they want to raise and I know from work that I have done that public recognition in the UK of the Ombudsman scheme is slight.

We commissioned an independent survey which showed that 17% of the public could recognise my former office. In Austria, where there is one single Ombuds, the public recognition rate is 70%.

There is an issue in all of this about who the Ombudsman serves in terms of need and one of the unfortunate features of Ombuds offices is that they tend to attract the people who are better educated and more well off than really the people who need the Ombudsman most, who tend not to -- to know who they are and to complain to them.

Q. In terms of managing complaints, Sir Robert, you set out at paragraph 12 onwards your processes and where there's primary investigations or detailed investigations. Can you briefly summarise that for us, please?

A. Yes. Can I just make one final point about the powers?

Q. Of course.

A. And that is in comparison to 70% of European schemes, the UK does not have the power of own initiative which is a crucial power for an Ombudsman scheme, in my judgment, to be able to look at issues which are not complained about but which are -- need investigation. And time and again there have been big issues which we will come on to which I would have liked to investigate which my partners in other countries freely can investigate as a matter of routine, but the governments of all parties have not given the Ombudsman that power.

So I think that is a campaign issue which needs to be thought of in terms of ensuring that people have the support of the Ombudsman in difficult situations and there's one particular case which I want to come on to, the case of Matthew Leahy where I could have investigated the whole case years ago before a Public

Inquiry, but I didn't have the power to do so, and I would like to come back to that.

In terms of how the process works, the Ombudsman office gets around 130,000 enquiries a year, mostly through telephone enquiries but some by email and so on, and the job of the front of the office is to take the telephone calls, to triage the cases, to see whether or not they come within the jurisdiction of the Ombudsman and if they do, whether they are in time.

Sadly and I think this is important, most of the enquiries that the office gets are from people who have either come to the wrong place or who have brought it prematurely, because the law requires that the Ombudsman does not consider issues until the body in jurisdiction has had an opportunity to resolve those cases.

So we have a lot of weeding out of issues that come to us that we can't handle.

We then make a judgment whether we can resolve the issues quickly, either by negotiation or by mediation, and mediation is something that I brought into the office which I learnt from international experience is a very important way of taking the pressure off investigation; by trying to bring parties together without forcing them and getting them to make the decision rather than the Ombudsman. Because of Covid

that's taken a long time to develop but it is now in place and it needs to increase.

But if it doesn't meet that term and we can't deal with it, then we will tell people that we can't deal with it very quickly.

We would then have a situation of around 35,000 formal complaints and of these around 8,000 would be suitable for primary investigation. That is we would have a look to see whether -- see what the issues are and to investigate in a -- in a light way to see what we could do.

If that is possible, then around 8,000 cases would come under to detail investigation which is much more systematic.

LADY JUSTICE THIRLWALL: You said 8,000 suitable for primary investigation?

A. Sorry?

LADY JUSTICE THIRLWALL: I think you said 8,000 were suitable for primary investigation?

A. For?

LADY JUSTICE THIRLWALL: You said originally 8,000 suitable for primary investigation, then you said 8,000 for ... and I wondered if you got the number wrong.

A. Yes, sorry. It's -- I think it's about, I'll find it in a minute but I think it's about 1,000 would

be capable of detailed investigation.

LADY JUSTICE THIRLWALL: Thank you.

A. Sorry.

LADY JUSTICE THIRLWALL: That is fine, I don't need the precise number, just the general --

A. Yes, no.

LADY JUSTICE THIRLWALL: -- ratio. Thank you.

MS LANGDALE: Setting standards for good complaint handling. We know you produced a publication on this. If we can have INQ0014511, page 1, NHS Complaint Standards. You launched this in 2021, Sir Robert, as a model complaint handling procedure and guidance.

Before we look at your foreword, I understand this arose through a Making Complaints Count report --

A. Yes.

Q. -- which prompted this. Can you tell us about the report?

A. Yes. I think the key challenge that the Ombudsman has is not to be a kind of police officer who's just looking for bad cases and to investigate those. For me, the idea of the Ombudsman is to support good practice and to try and encourage bodies in jurisdiction to be better able to handle complaints themselves so that people don't need to go to the Ombudsman to have those cases looked at and resolved.

When I was the Higher Education Ombudsman before I took on my former role, I noticed that in Scotland they had a very effective way of having a best practice complaints guide for bodies in jurisdiction. So I developed that for the Higher Education Ombudsman and when I came to PHSO I did the same at PHSO and we launched a two-year investigation to go round the National Health Service to look at the culture and the way in which complaints were handled to see what we could do to work with bodies in jurisdiction to make them better able to handle complaints.

What we found, and I think it's worth looking at, Making Complaints Count, because it was put before Parliament, is that those people handling complaints in the NHS when we spoke to them in private, and I went round a lot of NHS Trusts before Covid came in, I would go to Trusts and the Chief Executive and the Chair, good people, would say: we are all in this together, it's one big happy family, and then I would go and meet individual parts of the Trust and quite often talking to the complaints teams behind closed doors they would say: help, Rob, we need your help because we don't get support or investment from our Trust and unless we have that, we can't do our job effectively.

And part of it was because of the lack of status

that the complaints teams had in comparison to clinicians in the hospital, who they had to work with in order to respond to complaints and part of it was because there were no effective standards despite there being Government regulations about this issue.

So we worked together and co-produced the Complaint Standards Framework, first for the NHS and latterly for Central Government departments and it -- it's not the Ombudsman's complaints standards, it's a joint working project which worked with around 70 bodies in jurisdiction to pilot and refine ways of improving complaints handling in public service organisations and to professionalise what had been a "sitting next to Nellie" operation.

Q. If we look at your foreword on the document on the screen, pages 4 and 5, I will give people a chance to read it rather than me read it, page 4 and then page 5.

(Pause)

A. Yes.

Q. Then if we go in a moment to pages 13, 14 and 15. Highlighted at the top there, Sir Robert, is:

"Senior leaders create an environment where everyone is supported and empowered to act on learning, rather than feeling blamed."

The "feeling blamed", how difficult is it to achieve that in practice, where complaints arise, and ensuring those -- the receiving end of them don't feel blamed?

A. Indeed. I mean, this is an issue at the centre of NHS culture. Mistakes are bound to happen in situations where highly talented people are working under great pressure on complex issues and they make mistakes. And the challenge of leadership is not to stigmatise the people who make mistakes, but to create an environment in which those mistakes are not only owned but learned from and I think my experience over seven years was that still there was a tradition of blaming people who allegedly had made mistakes and we heard a lot from people working in Trusts that leaders were only interested in what they were doing providing they -- they were contributing in a way which the leaders regarded as positively.

And they wanted and it's true for the Ombudsman world as well, they wanted to be supported when they made mistakes and they wanted to be given the skills and the professional training to ensure that they didn't make mistakes when they -- when they came back to the situation. One of the key issues for me, perhaps we may come on to it, is that I have experienced a great need

for learning and development in the NHS and it's not obvious where that is always coming from.

I did a big report in 2017 about eating disorders and we were shocked to see the limited amount of training that doctors were given in their basic training when it came to eating disorders and we were equally concerned about the number of stakeholders who had responsibility for learning and development from universities to professional bodies and so on which meant it was extremely difficult to create a movement for changing the curriculum on eating disorders in a way which would beneficial people suffering from those things.

One of my concerns is that in 2022 the Government received what is called the Messenger Report on learning and development in the health service, which is a key document for addressing this very issue. And I have been disappointed to see that it hasn't yet been put into implementation and I think this is a key issue. You know, in every area that I have worked in as an Ombudsman in higher education, in -- in -- I was Complaints Commissioner to the Bar for two years, learning and development is at the heart of professionalism in a way in which I am not clear that it has been in the health service.

Q. If we can look at page 14, please. I don't have any questions arising but we see what's set out there.

Then page 15, being thorough and fair. If we see the third bullet point from the bottom:

"Staff give everyone involved in a complaint the opportunity to give their views and respond to emerging information where appropriate. They take everyone's comments into account and act openly and transparently and with empathy when discussing this information".

We are going to come on to defensiveness around culture and complaints generally. But how can empathy be encouraged and sustained in the context of complaint handling?

A. Yes. There is a brilliant piece of work done by Baroness O'Neill, the Reith Lectures of 2003, in which she writes about public trust in public institutions and she talks about the key elements for public trust and they include honesty of the leaders, competence of the organisation, transparency in the culture of the organisation and finally, and this is relevant to empathy, trustworthiness.

And it is not sufficient to be impartial and to follow a fair process in dealing with complainants and time and again, and this comes through all the reports

that I have published, or my organisation published, what people in difficulty want is to know that people respect the situation that they are in and can identify with it and have empathy with it and this has not been a strong point for the National Health Service.

And a number of people report -- I mean, in all of the reports that we have had, the lack of empathy shown to people in great difficulty is a key issue because it discourages people from feeling that they are being listened to. And again and again in the case of Scott Morrish, who lost his son to sepsis aged 3, Merope Mills, who lost her daughter, and we now have Martha's Law as far as that's concerned, James Titcombe. So many people that I have met I had on Radio Ombudsman, which is an opportunity for complainants to come and talk to the Ombudsman about what it really felt like, they have said: people have not treated me in an empathetic way to encourage me to believe that my case, my complaint, is being dealt with seriously.

And too often people feel that they are not listened to and they are not really at the heart of those people who are looking at what they are complaining about. I hope that's clear.

Q. Understood. Paragraph 24, you speak about the Ombudsman role in sharing learning from complaints to

improve services and you say:

"We share the lessons learned from our casework so that organisations can improve public services."

In terms of the guidance that's on the screen -- and that can actually go down now -- how was that circulated, distributed and encouraged as a tool for learning?

A. So, there, there -- I mean, the Ombudsman is not separate from the four elements of public trust which I have just described. If the Ombudsman doesn't replicate those elements by being honest, competent transparent and trustworthy then people are not going to use that service and that's very important.

One of the things that I have tried to do is to demystify, I tried to do -- is to demystify the service so that people understand what it is the Ombudsman does because people don't have a very clear idea of what the Ombudsman does.

So I tried and succeeded very largely in publishing for the first time summaries of almost all the investigations that we concluded on a regular basis so that people can go to the website and have a look at good practice, as we describe it, in cases which may not involve themselves. So that's one thing.

Secondly, the good practice framework is

an opportunity for people to professionalise themselves in what constitutes effective complaint handling. So we not only produced or co-produced model complaints handling, a series of key skills that you need to get things right, but we also introduced professional learning, continuous learning, CPD learning and development which is now accredited and we have had -- so far it's early days -- 2,000 people in the NHS who have undertaken this professional development programme to improve their skills as far as complaints handling is concerned.

Now, just to go back to my previous point, it's one thing to train complaints handlers and to give them the skills that they need. The Ombudsman introduced, for example, training in empathy and how to deal with trauma as a regular part of the induction and training of case handlers because they had to deal with that so importantly. But unless the leaders buy into this too, then it doesn't work for the organisation.

So when I left PHSO they were just developing a leadership programme for leaders to be able to better take the initiative on complaints and to support the people who are dealing with those things.

Q. You have given us, if we can go please on to the screen INQ0014599, page 5, in your statement the

numbers of complaints that you have received. It's probably easier for everyone to see the table, 26, 27 and 28 on page 5. We see there the number of health complaints received and you tell us at paragraph 28:

"The system had no specific flag available for neonatal complaints."

But if we go over the page, to page 6 of your statement, you helpfully identified summary keywords, relevant to us, and as a result of these searches we see at paragraph 31, you identified 68 cases, 65 closed cases and three ongoing, none involved the Countess of Chester Hospital.

In terms of those neonatal complaints we have seen those and indeed I have gone through that briefly. As far as you were concerned, were there any commonalities in the complaints as far as the neonates were concerned in the exhibit you provided us with?

A. We are talking about the Countess of Chester?

Q. Not the Countess of Chester, the exhibit that you provided with the 68 complaints relating to neonates. Just at any high level, in producing that, did you have any high level reference point going through them of commonality or not?

A. We -- we -- I know we are going to come on to it but we published two big reports, one on maternity

and the Broken Trust report which included a number of maternity cases from which there were themes which we might get on to.

Q. Right. But not from the neonatal few, because that's relatively few, isn't it, to have 68, or it seems it, relating to neonates?

A. Yes.

Q. Maternity I appreciate different category but for the neonates?

A. I can't -- I can't add anything to that, I'm afraid.

Q. No fair enough. Thank you.

That can come down, thank you.

I want to ask you please about the University Hospitals Birmingham NHS Foundation Trust. In 2023 there was a report published or you made considerable reference to that case yourself in the press. Do you want to tell us now what your view was or is about that?

A. Yes. Well, University Hospitals Birmingham has changed its leadership since -- since these events and so I am not talking about the current leadership of the Trust. But this is a very sorry tale of what was regarded as a leading NHS Trust and one of the biggest in the UK, where we were investigating a number of serious cases and we found a hostility from the Trust to

our investigations, a reluctance to co-operate with us in giving evidence, a slowness in response; and a rejection of the recommendations which we were making. And this followed intense engagement with people at the Trust.

And I was extremely concerned about this and so in consultation with my colleagues, I decided to bring the case to the Health Regulators Forum, which is a very important body, underused, which brings together all the health regulators to discuss issues of common concern. Now, the Ombudsman is not a regulator because the Ombudsman has no coercive powers. But the Ombudsman is part of the regulatory framework. And we brought our concerns to the regulatory forum which includes bodies like CQC and NMC and so on, GMC, and we expressed our concern about Birmingham and their lack of co-operation and there were some avoidable death cases that they were reluctant to own, and people around the table said: well yes, we know about this. This is not news to us.

And that was extremely disturbing because if it was not news, why hadn't it been brought to the forum before then?

And that's why I decided to go public on it and -- and express my concern about it. And in response, the Trust said that all the issues concerning complaints had

been resolved with the Ombudsman. That was a blatant untruth, it was not the case. They hadn't been resolved and subsequently, because of the furore around what Newsnight had done and what we had done, an independent review of the Trust was conducted, which shows a hostile environment for the staff working in the Trust, a feeling that they couldn't disclose patient safety issues, a general policy of reporting clinicians who wanted to disclose patient safety issues to the GMC as a way of disciplining them and encouraging them not to make complaints, a sense of tribalism in the relationship between the different clinical professions where -- where there were not good relationships between nurses, doctors and a failure by the Trust's leadership to have a grip on the clinical issues that they were dealing with.

And these are very serious issues that mean that people were working in an environment where they didn't feel safe to disclose and there was in my view a failure of leadership here which needed to be corrected and to some extent has been corrected.

Q. Indeed, you --

A. But just before -- can I say that this was not an isolated instance from other pieces of research which I have seen about the culture in NHS Trusts, in terms of

the Ockenden and Kirkup reports but we can perhaps come on to that.

Q. You referred publicly, didn't you, that you understood no fewer than 26 of its medics were reported to the GMC; is that right?

A. Yes.

Q. And you commented the GMC took no action against any of the 26 doctors but it did issue a formal warning, did it, to one --

A. To the Chief Executive.

Q. Yes.

A. I need to be clear. I don't think it was wise to have referred that many people to the GMC but I have seen subsequent claims by the Trust that there was evidence to justify some of the cases and not all of them were as clear-cut as the FOI information suggested it was.

Q. Outside of that example, are you aware of doctors being referred to the GMC or threats to referral to the GMC?

A. Absolutely.

Q. You say "absolutely". Are you confident about that, that that's endemic or does happen?

A. The whistleblowing law does not work in England and too often, in my experience, doctors who

want to disclose patient safety issues are disciplined or threatened with discipline by the leadership of the Trust and the board.

And this means that they are extremely vulnerable when it -- when they do blow the whistle and I have had as the Ombudsman considerable number of telephone calls from clinicians, A, in Birmingham saying: please don't give up, please don't stop because there are issues here that need to be addressed that haven't been addressed; and, secondly, from doctors in other bodies in jurisdiction who have rung me and have said: we want to raise a patient safety issue but if we do, that will be the end of our careers.

And that is not a good way to address patient safety issues and there needs to be a reform of the law not only on whistleblowing but on the duty of candour to make sure this doesn't continue to happen.

Q. How far have you come across counter-grievances being raised, so doctors raise a concern about might be about another doctor, it might be about a nurse, might be about any patient safety concern, and then there is a grievance or something else raised against them, something perhaps not to do with the specific concern but some other kind of allegation; is that something you have come across as a defensive

grievance --

A. Absolutely, I mean, this happens too -- too frequently. There is book by Dr Duffy about his experiences in Morecambe Bay where exactly this happened where he was concerned about the over-concentration on financial and productivity issues and not enough on patient safety and he basically lost his career as a result of this.

My concern is that unlike in Scotland, there's no opportunity for people who want to blow the whistle to have a body that they can go to in order to get support and advice. Now, we do have Speak Up Guardians in England and Speak Up Guardians do a brilliant job in being available to staff in the NHS and elsewhere if they feel that they have an issue which they can't raise with their manager and the reports of the Speak Up Guardians are very valuable in showing us the good work that they do.

But there are a number of things that need to be said about this. First of all, the Speak Up Guardian deals with issues before the whistle is blown. They are not dealing with whistleblowing.

Secondly, their annual reports show that there is an increasing number of people who do not feel safe to speak up on issues in -- in the health service.

And thirdly, I have had Speak Up Guardians who I've spoken with at conferences who feel that they are not able to be frank and open about their own experiences for fear that they too will be disciplined, which is not the point of the Speak Up Guardian.

Now, that is before you even get to whistleblowing. But --

Q. Tell us about the Scottish system and indeed your Scottish counterpart has a greater role, doesn't he or she?

A. Yes.

Q. So tell us about that and how effective you think it is.

A. Yes, I mean one of the great ironies, lamentable ironies, is that the UK Ombudsman does not have the powers of the devolved Ombudsman that were created in the United Kingdom fairly recently.

So the Northern Irish and the Welsh public service Ombudsman have the power of own initiative but we don't.

And in Scotland, the law has been changed so that the Ombudsman is the body to which people who want to blow the whistle can go and get advice about what to do in these difficult circumstances. And that -- you know that's not perfect, but it means there is a public body that people can go to to raise their concerns and feel

supported.

And the whistleblowers that I know and have met and I have spoken at the All Party Group on Whistleblowing, feel isolated and vulnerable when they do blow the whistle because of the bad experiences that so many of them have had. And I would just like to make this final point on that: if you look at the litigation costs and the compensation fees around whistleblowing issues, they are enormous.

In the Isle of Wight for example, the Director of Clinical Affairs there blew the whistle about how Covid was impacting on the Isle of Wight, she was dismissed, she took the Trust to court and she won a settlement of in excess of £2 million.

So, you know, it's not productive to handle cases in this aggressive way.

Q. What about the role of the Independent National Whistleblowing Officer in Scotland?

A. Excuse me?

Q. The role of the Independent National Whistleblowing Officer in Scotland?

A. Yes.

Q. Do you think that's a significant role in terms of setting out principles, procedures and an area of guidance?

A. So I'm not an expert on this and there is a debate about whether the Ombudsman should have this power to be the representative that people can go to or, as the All Party Group say, there should be a separate, independent office to which people can go.

In Scotland they have combined the two and it seems to work very well but the All Party Group believe that it should be an independent office. I don't know. But one of my concerns is the -- the flourishing of regulatory bodies in the last ten years in health in a way which is not productive and doesn't add to the competence of the National Health Service.

Q. We will come to that.

LADY JUSTICE THIRLWALL: That is perhaps more a proliferation than a flourishing, perhaps.

A. Yes, it is a pejorative term, flourishing.

LADY JUSTICE THIRLWALL: It just seems perhaps not --

A. Absolutely.

LADY JUSTICE THIRLWALL: -- what you meant.

Can I just ask before you leave Scotland, you mentioned there was someone that people could go to with their concerns and for help and advice as to what to do and then we looked at -- I think it's INWO, isn't it, the sort of national body of Scotland who carry out

reviews of how complaints have been handled.

Now, I think from what you just said it's that same office that is the one offering the advice which I haven't heard before, but I may have misunderstood your evidence?

A. Sorry. It is difficult to hear what you just said. Are you saying that the whistleblowing power and the Ombudsman in Scotland are under the same roof?

LADY JUSTICE THIRLWALL: That is what I was asking you because I thought that is what you had said.

A. That is the case, yes, sorry.

LADY JUSTICE THIRLWALL: So we had heard evidence about the review function of that body.

A. Yes.

LADY JUSTICE THIRLWALL: Indeed that's something we are going to have a look at. But I hadn't understood that they had the separate responsibility for advising individuals --

A. Yes.

LADY JUSTICE THIRLWALL: -- on what to do.

A. Yes.

LADY JUSTICE THIRLWALL: And it is the same body?

A. Yes.

LADY JUSTICE THIRLWALL: That makes sense of the next thing that you then said. Thank you.

A. Sure.

MS LANGDALE: In terms of your own experience as Ombudsman, you referred to an example -- was it one example or many where doctors did actually contact you to say: please investigate, please look at this, where they had concerns. Was that a rare event to take a call like that or did that happen quite frequently?

A. Yes, I'm not a sensationalist. It -- you know it's not common but it's not so uncommon that it should be ignored.

Q. In June 2023 you published a report, the Broken Trust report and perhaps this is a good moment to go to that, please. INQ0014545, page 1. And if we can go, please, to page 7. We see you set out in your foreword on the right-hand column, top paragraph:

"We consider the reasons for the continued failures to accept mistakes and take accountability for turning learning into action and improvement. We pose questions on how to embed an honest, open and unafraid culture in our healthcare system that supports staff and patients to challenge and learn."

If we go over the page, page 8. At the top:

"We identified 22 NHS complaint investigations closed over the past three years. Where we found a death was more likely than not avoidable, we analysed

these cases for common themes and conducted in-depth interviews with the families involved."

You set out, if I give people a moment, the findings.

(Pause).

Page 9, if we can. For recommendations, I will give people a moment to read them but I want to ask you about the last one, the last bullet point in a moment, Sir Robert.

(Pause)

A. The last recommendation or the last one on page?

Q. The last bullet point on this page.

A. Yes, so --

Q. What took you to that recommendation or ...

A. So I pay tribute to colleagues who are leading our regulatory oversight institutions. They have a very difficult job under very difficult circumstances and that should not be forgotten. But the government's tendency in the last 10 years in an area which is already highly regulated -- I mean, I am familiar with higher education, legal services, Central Government and now the health service, the health service is the most regulated sector that I have ever come across and what the Government has done has been to set up new

regulatory bodies whenever there's been a significant crisis in the health service without seeing what impact that has had on other regulatory bodies.

So we have had the creation of the Patient Safety Commissioner now under the brilliant Henrietta Hughes, who, you know, makes a wonderful contribution to what's going on. We have HSSIB, which is the body which is supposed to review serious issues in the health service and give a safe space, a so-called safe space to clinicians who wouldn't therefore be held to account and we have a maternity services body which was under HSSIB and has now gone elsewhere.

But what that means is that it is extremely difficult to know who has responsibility for what, even amongst those people who are part of the regulatory community. And because the regulatory forum has not been properly used, what happens is that there are a whole bevy of recommendations that come to either Trusts or the Department of Health which come in an uncoordinated way and I think this is not a productive way to promote competence in the health service. And I am pleased that since we published this report in 2023, the Government has commissioned a review by Penny Dash to have a look at this issue. And I think my successor, the interim Ombudsman, has contributed to

that review. But it does need looking at very carefully because it's not optimal at the moment.

Q. And in terms of --

A. It's very important that people understand who does what. If you look at mental health and where you make a complaint, I find it very difficult to understand the relationship between the Local Government and Social Care Ombudsman, CQC, and the Parliamentary and Health Service Ombudsman. You need to take a test to understand where you complain and if -- if that's my understanding or misunderstanding, what's it like for people in -- in the situation where they want to complain or they feel distressed?

Q. If we go over the page, please, to page 10.

Your bullet point at the top:

"The Government should seek cross-party support for commitments to embedding patient safety and the culture and leadership needed to support it as a long-term priority."

You make reference elsewhere to cross-party support. What do you think the significance of this is, needing cross-party support for our NHS?

A. Yes. Well, I think I wrote to the Secretary of State after this Public Inquiry was commissioned asking him as matter of urgency to include patient

safety and culture as a part of the wider remit of the Inquiry because I believe it's so important and so I am really pleased that you are undertaking this role and you do have a very important national role to play in -- in setting out the issues.

This is not something for party politics. You know, it goes to the heart of people's health and does need consensus in a way in which there hasn't been.

Q. How would you measure culture, Sir Robert? What's a good culture, how would you measure that?

A. Well, that's a very good question and I don't have the magic answers. But one of the things that concerns me is I am the chair of a university, governor at a new university which has made a contribution to society by training nurses and the number of young people who want to be nurses today is declining because people feel it's not the profession that it used to be and there's so much stress associated with it.

That can't be good for the health service. So that's one thing.

The second thing is if you look at the report of the National Audit Office I think in 2022, it said that the reason why 30% of people leave the NHS is because they fear for their mental health and they have high stress points and they don't want to risk their health

by continuing. That is very serious.

If that is diminished, then that is a sign that the culture might be changing in some way.

But the other thing is most of the reports that I have seen if we look, for example, at East Kent and what the brilliant Bill Kirkup did there and Donna Ockenden in Shrewsbury that many Trusts, and I can't be -- I can't say all Trusts because I just don't know, but many Trusts that have been reviewed show that it is unpleasant, an unpleasant environment in which to work, that people don't feel appreciated, they don't feel safe, they don't feel that leaders actually have respect for what they are doing and that can't be a way of creating a learning culture.

Q. How do you think the situation has arisen where they don't feel the leaders understand their work or value their work? When you say "leaders" do you mean senior managers in hospitals, leaders, Chief Executives, those roles or --

A. I think it's, a general point about boards, about Chief Executives and also about very senior clinicians as well.

Q. How has that arisen, do you think, that those senior leaders from the -- I am going to say jobbing nurses and doctors for a moment?

A. Yes.

Q. How is there such a chasm and a feeling of not being understood about what they are doing?

A. I think we have to pause and recognise and pay tribute to the many obstacles that the National Health Service has had to overcome in recent years in terms of finance, in terms of Covid, in terms of post Covid and demand, in terms of buildings, in terms of staffing, in terms of all kinds of things that the health service Trust leaders and the NHS and the Department of Health have had to deal with.

You know, that is an enormous difficulty for any public organisation and we have to pay tribute to that.

But what it's meant actually is at the end of the day that the issues about staff welfare and about the culture of organisations have taken second or third place to issues around productivity, finance and staffing and while that is understandable, it's not acceptable.

So that's one big thing.

The second big thing which we need to come on to is that the health service is not a body that regulates its leaders. It's not a body that gives training systematically to its leaders and to its boards in a way which means that the -- the boards and the leadership of

the NHS have become self-fulfilling elites who -- who have not had the benefit of training and development or -- or standing next to competences which they need to -- to fulfil.

So what you have, and it's happened too often, is that Chief Executives or board chairs who have presided over unfortunate events in one Trust have moved to another without there being any opportunity to say that they need to have appropriate training before they take on something else.

And in other professions I don't think that would happen. So I am encouraged by latterly the Conservative Government thought about this and now the new Government is consulting on this to bring in competencies for the leaders of organisations, I think that is very, very important.

Q. Is it another process, competencies and going through that? I mean, I see what you are saying about training and learning?

A. Is it another process?

Q. Another process, another layer of bureaucracy to be going through competencies? I understand what you are saying about learning and needing to have the skills?

A. I have read some of the whingeing from people

who say this is just box ticking and so on. It depends how it's introduced. It depends how -- the quality of the support that goes with it. It -- it is necessary, absolutely.

I know from my own experience as an Ombudsman that if there wasn't a set of competencies defined by the Venice Principles and the Venice Commission and training available with my European counterparts I would have been an even less effective Ombudsman than I was. But the fact that that was available to me gave me the opportunity to feel confident that I could address difficult issues. And I don't think that that's happened in the health service and that's why the Messenger Report does need implementing seriously.

Q. What was your understanding during your time as Ombudsman of the level of training that Chief Executives did receive in Trusts? Did you have a sense of that?

A. No.

Q. Can we just go back to --

A. I mean, I certainly -- it certainly wasn't something that was at the top of their agenda.

One of the interesting things about Birmingham where the Chief Executive was lauded as an example by the Department of Health of how Chief Executives could

operate.

But that was a fairly brutal regime and it wasn't ultimately successful. And I think, you know, we need to think very carefully about how to make even better the superb people who get -- who have those responsibilities.

Q. Can we look at two paragraphs down from the highlighted section on the screen, please. You say in the report:

"Tackling workforce shortages goes beyond political decisions about recording. It's about making the NHS a place where people want to work and stay because they feel valued, not just because it's a vocation. We must break down the false dichotomy between the interests of patients and staff recognising that a system that does not treat its workforce with humanity and compassion will struggle to extend these qualities to patients and families."

So how do you say we can make it a place where people want to work and stay because they feel valued?

A. Sorry, could you repeat that?

Q. How can that be done to make people want to work and stay because they feel valued in the NHS?

A. Well, this comes down to leadership and it comes down to resource and it comes down to regulation.

I mean, one of the things -- I think my colleagues in CQC and NMC are superb but those bodies have been publicly criticised in the last year for really their failure to be as competent as they need to be and for issues of harassment which also occurred in HSSIB taking place in the office.

Now, if these are the bodies that are regulating the health service, there is not much incentive for the health service and the Trusts not to do the same thing. You know, leadership has to come from the top and the regulatory bodies have to set an example, as do the politicians, about what constitutes appropriate behaviour and we haven't had that in sufficient quantities to be able to -- to address that issue.

And so all of the reports that I have put on the table have all mentioned the failure of clinicians to have empathy and sufficient communication with -- with their patients. This is not a side issue. This comes to the heart of patient safety. And that needs an effective human resources management response which we haven't had. Sorry, I don't have magic solutions to this and, you know, people more wise than I am would know a better way with how to deal with it but there does need to be a leadership revolution in the health service where leaders are invested in and brought to

account rather than blamed so that they can learn from what's happened rather than simply carry on.

One of the frightening things about Bill Kirkup's report into East Kent, which is a brilliant piece of work, and this comes, if I may say, my Lady, to -- to your challenge, he said: I ran the Morecambe Bay Inquiry 10 years ago, I have now done the East Kent Inquiry and nothing has changed.

And the issues are just the same as they were in Morecambe Bay. And that is because -- and this is a very serious issue not just here but across the board, that recommendations which Public and Independent Inquiries make are not sufficiently implemented in a way which makes a difference.

Q. Where does responsibility lie for that, do you think, where they are not implemented?

A. There is no body at the moment, as far as I know, which is the watchdog of the reports and implementation strategies of Public Inquiries and I saw you had a good piece of evidence about what had been implemented in other Inquiries. But that should be something that a prestigious public body should have responsibility for, for example the National Audit Office.

Why would it not have oversight of looking at

what -- what has been implemented and what has not been implemented?

And I think there is a real problem, if I may say so, with the way in which we commission Public Inquiries at the moment. They are ad hoc, they are political, they are not understood and it leads to injustice and failure in patient safety in a way which is distressing for the people who have suffered. I give two examples of that: one is the case of Matthew Leahy and my -- my investigation into the Leahy affair is in the pack.

A very tragic case of a boy, aged 20, who apparently took his life a very few days after entering a health institution. And what I found were 19 cases of maladministration by the Trust, a failure to sufficiently look after him, to give him a care plan, and when he died, his care plan was altered by one of the nurses who had looked after him which -- which is frightening. He alleged that he was raped while he was in hospital, there was no investigation into that at all.

Now, I published this report and I then discovered that he was not an isolated case but there had been at least 20 other cases in the recent past just like his case but because the parents had not complained about what had happened I was unable to investigate those

other cases.

So there was some investigation into this. And the Government reluctantly set up an Independent Inquiry to look at it. That Independent Inquiry failed because the clinicians would not co-operate with it and they had no power to compel people to step forward.

The Health Secretary and the Minister of State argued against there being a Public Inquiry for it. Eventually they conceded and only recently has the Public Inquiry started.

Years and years after I could have done an own initiative investigation and saved a huge amount of public money and minimised some of the distress associated with what Mrs Leahy, a magnificent woman, experienced, and that's not the only case.

The other example is the case of Robbie Powell which you may be aware of, who was a young boy who died of Addison's disease 37 years ago in Wales. And papers associated with his care went missing, there was a police investigation and a police cover-up. The report of the police investigation went to the Crown Prosecution Service. They sat on it for years and years and years and have only just concluded that the case is now too old to deal with. That should have been a Public Inquiry but the Government did not accept that

there should be one. But the rules are so arcane about what -- what constitutes a case for triggering a Public Inquiry that it's very difficult to say that they were wrong as far as this is concerned and it's only the magnificent campaigning of Mr Powell, Mr Will Powell, for 36 years that has kept this issue on the agenda.

Q. You use --

A. And I do think that there is an urgent need to review the conditions for creating a Public Inquiry which I was told by the Cabinet Office in 2020 they were on the verge of completing but it's disappeared altogether. But it is necessary.

Q. You use the term "cover-up" in your answer to that previous question. When does not being open and transparent move into cover-up, as far as you are concerned, because it is a very sensitive term, isn't it --

A. Yes.

Q. -- "cover-up", to talk about public body and covering up.

In your experience, when have you used that term and what distinguishes it from failing to be open and transparent which does seem different?

A. So when you -- we are talking about a small number of people here, we are not talking about the

health service in general. But it does make a difference.

In the case of Robbie Powell, medical notes were destroyed. In the case of Baby Ben Condon at Bristol in 2021, the hospital did not tell the truth about how they failed to treat the baby, what the problems for the baby were. And when there was a conference in which there was a discussion between managers at the hospital clinicians and Ben's father, a tape recording showed that the hospital staff felt they were incriminating themselves by putting this on the record and decided that they -- they shouldn't do this and they discussed eliminating the tape.

Now, that is a cover-up. You know, that should not happen.

There were things that happened in the hospital that Mr Condon, through a campaign, only discovered weeks and months after the baby had died and he has campaigned so forcefully that there is now to be next year a second Inquest into what happened because the revelations since the hospital said there was nothing to see here have been so great that the Coroner has decided to look at it again.

Those are examples of direct cover-up.

Where -- where there is a marginal issue is in the

case of the Broken Trust report, for example, where we felt looking at those 22 cases of avoidable death, in each of those cases, the Trust said: there's nothing to see here, there is not something that the Trust has done wrong and, therefore, it was an issue of a failure of appropriate investigation.

Now, we are not amateurs in this. The Ombudsman has recourse to clinicians, independent, to advise the Ombudsman about how the -- the Trust behaved and the courts have required that there be an Ombudsman standard on the use of clinical evidence to make sure that it's rigorous and appropriate. So it's not about amateurs making judgments about professionals. It's on the basis of independent clinical advice that the Ombudsman came to the view that in these significant number of cases, there was avoidable death which had not been reported. In another case, the case of Derek Richford, whose grandson died in East Kent, the hospital told him and his parents time and again that there was no need to report the case to the Coroner, that there was nothing for the Coroner to see.

It was only when Mr Richford rang the Coroner and said: should you be looking at this? And the Coroner's office said: "we know nothing about it yes, we should be looking at it" that he managed to get the case to go to

the Coroner.

Now, an organisation that wants to learn should not be in a position of not investigating properly and in too many cases we saw from Broken Trust the investigation was inadequate and it was a case of the Trust marking its own homework.

Q. You say in this report, page 12, and page 13, you set out the data, the last paragraph on page 12:

"We know there is a long way to go to embed working cultures that can learn and improve in response to failings in some part of the NHS. In the latest NHS staff survey [this was 2023] nearly 40% reported they did not feel safe to speak up about anything that concerns them in their organisation."

At the top of the page, 13:

"In clinical safety specifically more than a quarter of staff did not feel secure raising concerns about unsafe clinical practice and nearly 40% did not feel confident their organisation would address their concerns about unsafe practice."

You comment there that that's a worsening of the position from the previous two years.

How can we reverse that?

A. I think the briefing that I have says that in one of these figures the position has slightly improved

in the last year, so, you know, it's not universally all this way.

First of all, it has to be acknowledged that this is an issue. So this is a big thing. So many times Trust leaders have said to me: Rob, you are undermining us by pointing out that we are doing things wrong and people won't trust us if you keep on doing this.

But my point, going back to Baroness O'Neill, is if you are not honest and competent you can't be trusted. So you have to acknowledge where things go wrong and I think that is extremely important to recognise that these -- these situations do exist.

Secondly, the duty of candour does not work and needs urgent reviewing and replacement with stronger powers. So we don't have the legislative underpinning either by whistleblowing or with the duty of candour to enable people to feel that they have the backing in order to tell the truth and to disclose. Now, I have looked at the duty of candour.

Q. Perhaps while you are speaking we can put page 26 on the screen from this report, which sets it out from there, but carry on.

A. Sorry, I didn't hear that.

Q. You were just about to speak to the duty of candour so I am just asking we put the page in the

report that addresses it?

A. Thank you. Yes.

I mean, it's not -- it doesn't work because it doesn't apply to individuals, it applies to persons and that is interpreted as a public body and, secondly, the fines for it are so puny that it doesn't have any impact on the behaviour of the leaders of the Trust.

And so there is time and again, from cases that I have seen, a failure of staff to disclose what really happened in situations and the way that that happens in my view is wrong, which is that HSSIB has been created to give a safe space to clinicians to say what really happened without them giving a -- being held to account.

I took that case and it was in the Health Service Bill, I took it to the Venice Commission and argued that it was a breach of the Venice Principles and I was opposed by the Department of Health when I did that.

The Venice Commission came out unanimously in support of the Ombudsman and against the Department of Health, but the Government would not back down as far as this is concerned.

So what you have is the possibility of people disclosing what happened without being held to account for it and I was told that that happens in the airline industry and you don't therefore get as many accidents

as you used to have as a result of that.
But there's no Ombudsman in the airline industry and in Scandinavia, they have HSSIB equivalents where the Ombudsman is part of the safe space. The law says the Ombudsman can only be involved in the safe space with the permission of the High Court which, with respect, judicialises the role of the Ombudsman in a way which was not a good idea. That is not what the Ombudsman does.
Q. Can I --
A. So I am not content that the issue has priority, I am not content that the issue has the underpinning of law that it needs in order to make it work.
Q. Can we look at page 27, please, the next page. The second quote, as somebody who had used PALS said:
"I feel like it was a very distressing situation. There was no sort of advice around the complaint. I first complained to PALS which work in the hospital. I don't actually think that this is a good way for patients to complain about the hospital because the people they complain to work within the hospital."
LADY JUSTICE THIRLWALL: The people they complain to?
MS LANGDALE: "... work within the hospital."

So have you got any experience or knowledge of PALS or feedback in your role as Ombudsman about PALS?
A. Yes, we -- we know that where -- I mean, this comes back to my point about who uses the Ombudsman service.
Where people have an advocate, then they tend to be more successful in navigating the system than they would be if they had to do it on their own and organisations like PALS, which I know, but other bodies make a great contribution to enabling people to address the gap in power between the body in jurisdiction and between the individual. So this is why empathy is so important.
The Ombudsman has to be impartial between the complainant and the body in jurisdiction. But the Ombudsman also has to recognise that Trusts will use their enormous financial power to legalise and equip themselves to address cases that individuals on their own can't easily do and an advocate helps to more equalise a situation which is extremely unequal.
Q. Page 31, please, and the report references the Patient Safety Incident Response Framework that was being rolled out across the NHS with the deadline for implementation brought in 2023.
Do you have anything to comment upon this?
A. Yes. So I think we are in agreement that the

previous system did not work effectively and in the big case of the death of Averil Hart, for example, on eating disorders, there was a real reluctance of separate bodies to come together to undertake investigations about avoidable death. They didn't want to do it. They left it to each other to do it whereas we investigated eventually, because we were too slow in looking at it, but eventually we looked at the case as a whole and had to do that.
But the fact that so many cases which we have looked at haven't been effectively undertaken means that the new Patient Safety Incident Response Framework is very important and we support it and we want it to work.
But I think we made the suggestions in the recommendations that integrated care boards should have more of a role in looking at how these frameworks work and we also felt -- and this is very important -- Bill Kirkup said in East Kent that the board of the Trust was not interested in the clinical failures that were occurring in East Kent; it didn't feel it had ownership of that. That is very serious when that happens.
But it's also -- that was also we felt the case in Birmingham as well, when -- when there were serious issues.

The board has to own these issues and we proposed that a member of the board of the Trust has a responsibility for overseeing a Trust's framework responses so that if there are issues that they are concerned about, it's discussed at board level.
MS LANGDALE: Thank you. I think that is a good moment for a break now, if we can, Sir Robert.
LADY JUSTICE THIRLWALL: Thank you very much, Ms Langdale. So we will take 15 minutes, we will start again at a quarter to 12.
(11.29 am)
(A short break)
(11.45 am)
MS LANGDALE: Sir Robert, we stay in your report "Broken Trust: making patient safety more than just a promise" and on the screen we have page 34, and "Inadequate apologies" and you set out:
"Guidance from NHS Resolution makes it clear that apologising is not an admission of fault or liability. The same guidance highlights that organisations must make meaningful apologies when things go wrong. It states that a meaningful apology is vital for everyone involved in an incident, including the patient, their family, carers and the staff that care for them."
Can you expand on what a meaningful apology is and

in fact we could have page 35 on the screen while you do so as well?

A. Yes. In my experience, too many bodies in jurisdiction are grudging and lacking in sincerity when it comes to apologies and there is this view wrongly held that if you apologise, you are admitting to doing something wrong.

Now, we know from research which we have done, independent research, that when people come to the Ombudsman they want two things: they want to know that what happened to them would not happen to somebody else in the future and so there should be a policy development or an operational development, but secondly they want a sincere apology. And if they don't consider it to be sincere, then they get cross and disillusioned.

What's interesting, we, we award around £500,000 a year to complainants who have experienced poor service or maladministration and that's not the reason why people come to the Ombudsman. You know, they want an apology. They want -- it's part of the empathy issue and you can tell when it's written in a grudging way that it's inadequate.

There's guidance around from people who have written about this, some of my colleagues in the academic world in Scotland, for example, have written

about what constitutes a meaningful apology and this is part of the learning and development issue that Trusts need to get their act together on this and be more generous and empathetic when they are dealing -- when they are writing letters.

Q. The example we see here "I'm sorry if you felt that ..."

The use of the word "if", top paragraph?

A. Sorry?

Q. Apologies:

"Advocates told us they often see organisations send apology letters that say 'I'm sorry if you felt that' ..."

The use of the word "if"?

A. Yes.

Q. You know, what does it add in that situation? Or what does it take away?

A. Yes, yes.

Q. Page 39 of the report. This is the second recommendation. You say in the third paragraph:

"First we are becoming too used to seeing repeated failings. This is especially stark in maternity services and in his Inquiry in East Kent, Bill Kirkup made analogy to the disappointing familiarity of the findings to those he made in Morecambe Bay seven years

earlier.

"The fact that Inquiries many years apart find the same failings is met with dismay but not always outrage or even surprise. There is almost an acceptance that this is how things are. This inertia undermines the difficult work under way to change cultures and manage patient safety more effectively."

Addressing that acceptance, how can we remove the acceptance that this is the way it is?

A. Well, that needs political leadership and it needs leadership in -- in the NHS and from the Department of Health. Reading the brilliant work of Bill Kirkup, it's chastening. So he wrote at the end of his Inquiry into East Kent that: there's no point in me making detailed recommendations because what I proposed before has not been adopted.

The same issues are relevant as they were 10 years ago: the failure of teamwork amongst clinicians, the failure to listen to -- to patients and their families, you know, the failure to investigate appropriately and the failure of the board to be interested in what's going on.

Now, that is very worrying. But it's a cultural issue and it needs to be addressed and you do need political leadership to do that.

Q. At the bottom of the page, you repeat, we went earlier to:

"The Government should seek cross-party support from embedding patient safety and the culture and leadership needed to support it".

If we go over the page to page 40, tackling work shortages, which we discussed before, is about making the NHS a place where people want to work and stay because it's somewhere they feel valued, not just because it's a vocation.

Just on payment structures, and from your perspective and experience, do you think that payment structures contribute to tensions or unease between management and doctors, doctor and nurses?

A. Sorry, I didn't -- it is so --

Q. Echoey?

A. I didn't quite catch the question.

Q. Do you think payment structures contribute to tensions or unease between senior management and doctors, senior management and nurses? The way people are remunerated in the NHS?

A. I mean, that, you know, it applies to everybody doing very difficult jobs, under huge pressure and quite often subject to very critical and sometimes abusive behaviour by people that they serve, that what

they need is not only respect from their employer and the skills that are required to do a very difficult job but also to be properly, appropriately remunerated.

And there are some difficulties here because Trusts spend an enormous amount of money on bank staffing and that creates problems because the people who come in on a temporary basis are often not familiar with the individual patients that they are dealing with and so the service that they provide is not always as astute and sensitive as it -- as it needs to be.

I don't -- you know, I am not allowed, I wasn't allowed to be engaged in party politics so I don't want to comment on -- on pay issues.

LADY JUSTICE THIRLWALL: No, no, I think the question was directed more at what may be perceived to be a disparity between what managers are being paid and what clinicians are being paid.

A. I see, sorry.

LADY JUSTICE THIRLWALL: And does that contribute to unease and tension?

A. I am sure it does. But there, there -- in a number of cases and reports that I have seen there is real tension between the managers and the clinicians and that's not just down to financial issues, if I may say so.

LADY JUSTICE THIRLWALL: No, no, we were just asking whether that is one of the issues.

A. Yes.

LADY JUSTICE THIRLWALL: What are the other issues in addition to any you have already mentioned?

A. Sure. There is an issue of status and hierarchy and the sense, as Bill Kirkup calls it, and it comes out in the Birmingham report as well, of an exclusivity amongst clinicians who sometimes -- and we can't overgeneralise about this -- believe that they don't need to listen to anybody else about these issues, certainly not management.

And that -- that from my experience cases some Non-Executives to shy away from confronting clinicians as a result of that.

MS LANGDALE: We can take the report down now, thank you.

Going back to your statement, Sir Robert, at paragraph 47 you say too many leaders -- or you said in the context of a particular case where a hospital had changed medical records, you said:

"'Too many leaders are interested in preserving the reputation of their organisation rather than listening to citizens who have legitimate complaints...'"

Would you like to expand on that, what do you think

the importance of reputation is to a Trust and why?

A. This is very difficult but it's fundamental.

Time and time again we have seen through behaviour that senior managers and boards are more interested in preserving the reputation of their organisation than dealing with patient safety issues and this must have something to do with the culture of the leaders of the health service and it must have something to do with the absence of a competence framework in which these people operate.

And that goes really to the heart of what's wrong about the leadership of the NHS and historically and this is not a party political point -- there has been insufficient emphasis on patient safety despite the large number of things that have been done on the patient safety front to make leaders convinced that they have to put that first when there are other big issues about the status of Trusts, about finances and so on and if you don't have the political leadership to deal with that, then it's not going to happen.

Q. If we can go to paragraph 78 we asked you about hearing concerns and staff raising concerns and you say here at paragraph 78:

"A further barrier identified by Freedom to Speak Up Guardians results from the unintended adverse

consequences of strict professional hierarchies -- nearly 60% of those surveyed identified such hierarchies as having either 'very strong' or 'noticeable' impact as a barrier to speaking up."

And you say:

"This is of particular concern in the context of maternity and neonatal settings."

And you say:

"The report on maternity and neonatal failings in East Kent Hospitals ... highlighted dysfunctional relationships between obstetricians and midwives and noted specifically that 'hierarchy disempowered staff from speaking up'."

The Inquiry has heard evidence from Professor Dixon-Woods who has described something else as well in the area of barriers and bullying up, that you can have bullying up through the hierarchy, so you have a group that at first blush looking at the structured hierarchies you wouldn't expect to be the ones that bully, but bullying up can occur as well. Is that your experience, that you have seen that where going against the rigid hierarchies there is bullying?

A. Well, I have great respect for Professor Dixon-Woods's evidence which I read with great interest.

I think there's so many mixtures for -- there's so many variations on this theme of cliquiness and a failure to work together that -- that it's difficult to generalise.

So, for example, there are, there -- there historically has been tension between nurses, midwives -- nurses and midwives and clinicians about what is called normal birth and sometimes it's been nurses who have argued that normal birth is not sufficiently recognised in hospitals when people further up the clinical hierarchy have -- have not had that view.

So I -- I would accept that is the case.

If you look at the death of Martha Mills, that is very instructive for us because when she died -- you know she died of sepsis when she was 13 and she fell off a bike --

LADY JUSTICE THIRLWALL: Yes, I think it is a very well-known -- very, very well-known and sad case.

A. And Merope Mills spoke at the launch of the Broken Trust report. Now, there are two important things that I draw from that: one is that she made it clear that junior clinicians were afraid to approach the emergency services in terms of acute care for fear of upsetting more senior clinicians and that that meant

that not enough was done quickly enough.

Secondly, this is a woman who is a Guardian editor: highly educated, articulate, and she felt she was patronised by the nurses and the doctors who had the care of her daughter. If that applies to her, what about people who aren't editors of The Guardian? So to me, it is a real test case of what is wrong.

So I -- I accept what the professor said about that but I haven't come across it a great deal.

MS LANGDALE: From paragraph 91 onwards you deal with the accountability of senior managers and you refer to a false binary:

"We should be wary of any false binary between clinicians and managers in these discussions."

You say that at paragraph 92.

A. It is not on my screen.

Q. No, sorry, that will just be in your statement, that is not on the screen. At paragraph 92.

You say:

"We should be wary of any false binaries between clinicians and managers in these discussions. One in three clinically trained staff are engaged in management activities of some kind and a third of NHS Chief Executives have clinical qualifications. When registered clinicians are in management and leadership

roles, codes of professional practice still apply."

So you are making the point that for a number of them, it is not particularly relevant whether they are regulated elsewhere because they are already regulated by their professional body.

A. I think there is a problem, a general problem, I have seen it: when clinical directors become Chief Executives, they don't necessarily change their behaviour or their disposition and they retain, from what I have seen, a loyalty to the events that occurred when they were clinical directors. And where there's an absence of competences, then that will have an impact on the quality of their leadership. So I don't think we should underestimate that.

Q. What competencies would you say are necessary for a Chief Executive in the NHS?

A. I am sure there are people better qualified than me to answer that question.

LADY JUSTICE THIRLWALL: Yes, you are not the first person to be asked and don't feel you have to answer it, but if you have got any insight that you think might be helpful.

A. So there are all the issues that the NHS has to confront in terms of the issues that I talked about: you know, finance, funding, demand, merging with other

bodies. But the soft stuff, the people management, the leadership issues, how to take people with you, how to listen to your staff in a way which is appropriate is fundamental to the leadership role and that has been neglected.

We saw that in Birmingham. You know, people were crying out to belong to the community of University Hospital's Trust and they didn't see it demographically, or in terms of behaviour. It just wasn't manifest in the behaviour of the Chief Executive who was lauded as somebody who was able to steer an organisation through very difficult financial crises and was tough with his staff. I think that is a fundamental mistake.

If you -- if a Chief Executive does not listen to the voices of the people in their organisation, they are fundamentally failing and unless that is set out in competency terms, it's not going to be easily adopted.

Q. Paragraph 94 --

A. Can I just say that applies to the Ombudsman as well, you know.

When I became the Ombudsman people said to me, "Look, we're doing a very difficult job. If you don't listen to us, if you don't give us the skills that we need, and if you don't defend us when things go wrong, our relationship is going to be troubled." Now, that

doesn't mean to say you constantly give in to what people want -- we have had our battles -- but you need to be perceived to be listening on a regular basis and I don't think enough Chief Executives do that.

I will say that one of the things I think is very important -- it doesn't exist as far as I know in the health service -- is that Ombudsman peer review brings in other Ombudsmen to comment on what they see in another organisation. That could be enormously valuable in the health service, but it doesn't seem to happen.

Q. Peer review across hospitals, you mean?

A. Yes.

Q. Peer review of Chief Executive to Chief Executive --

A. Yes.

Q. -- or --

A. So I have done peer reviews in a number of countries and I have been subject to peer review, and you learn as much from being subject to peer review as you do from going and looking at how other people work.

And it's also very important; one of the key things I think is stealing other people's ideas and there is a lot -- we said this in Making Complaints Count: there is a lot of very good practice in the NHS which can be borrowed or stolen or developed. In terms of people

management the PENN annual reports that take place are a wonderful testimony to the good practice in the health service. We now -- the Ombudsman now sponsors one of those awards.

But that doesn't happen unless you have a look round. So I think people tend to be too tunnel-visioned when it comes to this and that's not helpful.

Q. You say at paragraph 94 as you have in oral evidence that the:

"Government should act on the recommendation from the Kark review to implement a mechanism for disbarring NHS directors following serious misconduct."

What about -- I mean, serious misconduct sounds a given, doesn't it, that they shouldn't be able to, having been found responsible for serious misconduct ...

But what about poor leadership or just not being very good at the job? What about the revolving doors in those cases where you can't ascribe serious misconduct but they are just not effective or not the best?

A. But a competency -- I understand what you are saying.

Q. Yes.

A. And I agree with you.

A competency framework is not about necessarily disciplining people for every failure. It's a document

that you use for critical personal and professional development and so on an annual basis, a senior manager should have the opportunity to get frank feedback about how she or he has performed in the last year against competencies with suggestions about how it might go better and with congratulations on how well it's gone.

I don't see it as just a stick to beat people with. It could be a cause for celebration of what happens.

Q. You set out from paragraphs 95 onwards in terms of a new regulatory system, for senior managers, it would need to be done with several caveats in mind. First of all, you say:

"... there must be wide-ranging and careful consultation to avoid unintended consequences. It is already challenging to recruit and retain high-performing senior NHS leaders, as there is a small pool of candidates for this demanding work."

Why do you think there's a small pool of candidates for this demanding work and what can be done about that?

A. Yes, I -- I think what I am trying to say here is that it's not like a magic bullet that you just fire and everything's okay.

I think one of the difficulties that I have witnessed is that there is an element of the magic circle about leaders in the NHS. If you look at the

leadership in Trusts and people tend to go from one to the other and it's more difficult for new people to come in. And that magic circle is not healthy but where there's no competency framework and where you can't take notice of the failure of people in their previous jobs, then I think it becomes self limiting and too narrow.

One of the things I have noticed is that I'm not sure it's a good idea that ICB leaders become Trust, Trust board chairs and I think that's too, too close to -- I won't use the word "incestuous" -- but I think it's, it's not a good thing. It needs to be healthier in terms of where you recruit people from.

Q. A challenge?

A. And the other thing is this, and I know this: that organisations that are successful where people have a record of being listened to and it's fun to work in, are better able to recruit people at senior levels than those where you're asking people to -- to go into a crisis situation.

Q. You say at paragraph 99:

"Further regulation involves adding additional process and bureaucracy on to an already complex and overstretched system. Therefore, we should adopt a cautious approach and regulate further only where we can be confident that the gains will outweigh the

significant costs."

A. I think, if I am honest, that was the advice of a cautious colleague in drafting this and, yes, you -- we need to be cautious, but that's not a reason for not adopting this process.

Q. But you do conclude:

"In my view, effective regulation can indeed contribute to cultural change, but it cannot deliver it on its own. Leadership behaviours will always be the most important determinant of culture and we cannot allow a focus on regulation to district from the urgent need to improve the quality of leadership in the NHS."

A. One of the things I was pleased to see was that Wes Streeting is proposing to set an institutional mechanism for training in the NHS, a leadership dimension to that. I think that is very important. I think it's long overdue. But we still need to see the colour of the money of the implementation of the Messenger Report to ensure this happens.

MS LANGDALE: Thank you. Those are my questions, Sir Robert, and Mr Baker, King's Counsel, has some now on behalf of the Families.

LADY JUSTICE THIRLWALL: Mr Baker.

Questions by MR BAKER

MR BAKER: Sir Robert, good after -- good morning

I should say.

I ask questions on behalf of two of the Family groups. Describing the history of how so many of the NHS scandals came to light, you can see at the heart of them bereaved parents or grandparents whose grief makes them into powerful advocates?

A. Yes.

Q. Do you think the fact that they have to become powerful advocates to expose these problems is a problem in and of itself?

A. It is absolutely. One of the -- one of the great things that I have learnt as Ombudsman is the heroic behaviour of parents and family members in seeking to keep cases going, which otherwise would have fallen by the wayside and that should not be the case.

But I looked at the evidence given to our Ombudsman open meeting with Scott Morrish, whose son died of sepsis, and he had long years of trying to get justice for his son and what he said was the last thing in the world you want to do when you have lost a son is to complain or to have to campaign about it. And other people have said to me that they can't begin grieving until they have addressed the issues of the justice or the misjustice that has taken about.

So parents in this case are to be hugely commended

for their courage and tenacity in taking this forward and it's frightening to think how many cases would have just disappeared without their continuity.

Q. That brings me on to the next question.

There is inevitably a huge power imbalance between an NHS Trust and a bereaved parent?

A. Yes.

Q. It becomes more profitable, doesn't it, to obfuscate, to deny, even to cover up because so many people just go away, they won't carry on pursuing the issue in the way that some of these powerful advocates have done. How do you combat that? How do you stop it?

A. Well, it's not always profitable. I think it depends how you, you measure these things. But where the NHS spends around £7 billion a year on compensation for medical negligence, between 2 and 3 billion on maternity related issues.

So in the long run, it's not profitable to pretend that issues don't exist and it certainly doesn't win the trust of the people that you are trying to serve, which carries with it immense challenges for people who work in the organisation.

But I agree with you that in the short term it could be seen as a good option and it isn't.

Q. Yes.

A. And we all have the challenge of persuading people or making rules to ensure that they see that patient safety and honesty and competence have to come first, not second.

Q. So there is an interrelationship between candour and patient safety. We shouldn't view them as being in separate silos?

A. Absolutely, absolutely.

Q. How does good candour lead to good patient safety?

A. Well, good candour is about disclosing what really happened or what you are concerned about in the day-to-day activities of your -- of the Trust and that is the basis upon which people in positions of power have to make decisions about what should be done and what should not be done.

If they don't have the evidence for that, if people don't disclose because they are fearful of what might happen, then some of the issues which need to be addressed will simply not be addressed.

So I think there's a direct correlation between those two things and the problem is, as I said before the break, that there's no incentive for people to rely on the duty of candour because it has no powerful impact when it goes wrong.

Q. So we see then the two concepts: candour, whistleblowing or speaking up and the power to speak up, all feeding into a culture of patient safety?

A. Absolutely.

Q. So the Trusts who are candid and reflective about the errors that are made and Trusts that allow people to be the eyes and ears of their organisation, to speak up about patient safety issues, they all create a culture of good patient safety by doing those things?

A. That is absolutely the case, yes.

Q. Yes. The same issues about reflection, learning and addressing patient safety issues appear to come up within all of the press release statements that you describe within your witness statement.

So discussing a number of different Trusts, Birmingham, East Kent, no doubt in near future we will be adding Nottingham to the list as well. But all of those cases you point to issues with openness and learning, listening and learning is the way that it's put in your witness statement.

A. I -- I was very pleased that both Lord Darzi in his report on the state of the NHS when the new Government came to power, and the chair of the Public Inquiry into blood infection quoted what I had been saying about this issue as being fundamental to

resolutions.

Now, I need to disclose that I am now a Non-Executive on the Infected Blood Compensation Authority so there's a conflict of interest potentially there. But I think it is now being seen to be an issue that needs to be addressed as a matter of urgency.

Q. Yes, but the repeated references to listening to staff and patients, learning from mistakes, they seem to be the same thing that appears in all of the --

A. Yes.

Q. -- NHS scandal cases.

Is it that those failures are features of dysfunctional Trusts or is there something that's part of the culture of the NHS in that?

A. It's very difficult to say because the Ombudsman tends to receive and focus on cases which go wrong. That is the pabulum of what the Ombudsman looks at. So I can't be absolutely clear about that, but it is a significant issue.

Q. Yes.

A. And it, you know, it's not to be ignored.

Q. It seems to be a common thing though, doesn't it?

A. It's common enough, absolutely.

Q. It seems to be the same story?

A. One of the things I learnt going round Trusts is that sometimes the Trust varied depending on what ward you went to and what the leadership of the ward was like. So, you know, you would have an outstanding nurse in charge of a particular ward where the culture was very different from one where there was a routine leadership of it.

So we need to be careful. We need to accept the huge diversity that exists in an organisation which is so large. But, broadly speaking, it's too common to be anything other than a big concern.

Q. Yes. So if one were to look at key issues in identifying taking the temperature of the culture of the Trust, its candour with those who are injured or affected by its actions would be one place to take the temperature and its reaction to complaints or patient safety whistleblowing, speaking up would be another key place to take the temperature?

A. Yes.

Q. And its performance in relation to those two issues would give you a good idea of its overall attitude towards patient safety. Would that be a fair statement?

A. I would add in the way you treat your own staff --

Q. Yes.

A. -- and how able they feel to join in the conversation about what matters and what's going on.

But, yes, I agree with you.

Q. Finally, when you talk about listening to patients in your statement as being a key feature, do you mean also within that there should be a dialogue with patients, it shouldn't just be the Trust listening to patients, but the Trust should be providing the patients obviously with adequate information to be able to raise issues?

A. Yes. And I think that's what we now have in the large experiment over Martha's Rule, where 143 Trusts are participating in the pilot to see how further advice from outside the particular treatment that's going on will -- will take place.

And there's a wonderful body run by a woman called Sarah Barclay called the Medical Mediation Foundation which trains clinicians to talk to parents of children with very serious illnesses in a way which encourages them to have a conversation rather than to say: this is the case.

And I think, I have talked to some doctors who say that that's not how they were brought up; that when they were brought up they were told that they should rely on

their own judgment and they should stick to it, come hell or high water.

Listening to the families of the people you are working with as we showed in the maternity report, the sepsis report, the Broken Trust report, it doesn't undermine your credibility, it actually increases it.

And I know as a patient -- and I had my life saved by the NHS, I have no, no interest in rubbishing it in any way -- but I know that my confidence in the clinical treatment that I was getting was always enhanced when people came to say: This is what we are going to do. What do you think?

Q. Indeed.

A. It respected me as an individual rather than just as a patient.

MR BAKER: Thank you. Thank you, my Lady. I have no more questions.

LADY JUSTICE THIRLWALL: Thank you very much, Mr Baker.

Questions by LADY JUSTICE THIRLWALL

LADY JUSTICE THIRLWALL: Sir Robert, thank you very much for the evidence you have given so far.

I just wanted to go back to one point which is one of a number of very interesting points that you have helped about.

You mentioned in the context of complaints the fact that the teams that you spoke to who were dealing with complaints within a hospital felt that they weren't recognised, that they were of low status generally.

Have you seen any improvement in that in recent -- had you noticed any improvement towards the end?

A. Yes, I saw Professor Dixon-Woods said it was too early to be able to make a judgment about that.

LADY JUSTICE THIRLWALL: I had forgotten that, so thank you for reminding me. Not an original question, then.

A. No one is saying to us that the Complaint Standards Framework is a waste of time. There's huge support for it in -- in the NHS regardless of what position people are in. As I said, 2,000 people have undertaken the professional qualifications.

The key to it is that it's co-produced so it's building on what the Trusts themselves and the GP practices have done and enabling them to have an opportunity to -- to show -- strut their stuff to show what's good that works. So I think that's very encouraging.

When I was the Higher Education Ombudsman I had time to produce an annual report of what impact the standards that we had published met and I hope that --

and that's good, that -- you know, that really encouraged people to have a look at what impact the practice was having. The Ombudsman hasn't done that yet but hopefully it will in the next year and that will point to what's going well and what could be done better.

It needs to be treated as a project, not as some stone that comes down from Mount Sinai. You know, it should change all the time as people become more experienced in using the framework and as they share experience. So that's why we wanted it to be a live document rather than like an NHS Regulation which just sits there year after year.

LADY JUSTICE THIRLWALL: Thank you. Anyone want to ask anything else arising out that that?

MS LANGDALE: No thank you, my Lady.

LADY JUSTICE THIRLWALL: Thank you very much so, Sir Robert, thank you very much indeed for coming and giving us so much thoughtful evidence in addition to the documents that obviously you have also provided. We are very grateful to you and you are now free to go.

A. Thank you very much, for your courtesy and for your questions.

LADY JUSTICE THIRLWALL: We will let you depart the stage. You don't need to wait for us.

Ms Langdale, we are back on Thursday.

MS LANGDALE: Thursday 10 am.

LADY JUSTICE THIRLWALL: 10 o'clock.

MS LANGDALE: The first witness is by videolink.

LADY JUSTICE THIRLWALL: That's right, I knew there was something that I had to remember. So 10 o'clock, but we are convening here?

MS LANGDALE: Convening here, videolink with Dr Fletcher.

LADY JUSTICE THIRLWALL: Very good and perhaps we will make sure in advance that the quality of the link is better than it was at the beginning.

MS LANGDALE: I am reminded by Mr Suter we are starting at 9.30 with the videolink on Thursday.

LADY JUSTICE THIRLWALL: Yes, that was the thing I was trying to remember.

So we will rise now and convene again 9.30 Thursday morning. Thank you all very much.

(12.29 pm)

(The Inquiry adjourned until 9.30 am on Thursday, 12 December 2024)

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