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Shared Insights

Learning lessons from national inquiries

Panel of speakers

Moosa Patel, Director of the Office of Modern Governance
Eleanor Grey, KC of 39 Essex Chambers
Gerard Hanratty, Partner and Head of Heath and Life Sciences at Browne Jacobson

Browne Jacobson

Introduction

This session was chaired by Browne Jacobson's Gerard Hanratty, Partner and Head of Heath and Life Sciences at Browne Jacobson.

We were delighted to be joined by Moosa Patel, Director of the Office of Modern Governance, and Eleanor Grey KC of 39 Essex Chambers.

Moosa Patel established the Office of Modern Governance in 2017 and has worked with a range of organisations to review and enhance their governance. This includes leading several investigations and nationally and locally commissioned reviews into NHS governance failures. Prior to that, during a career spanning over two decades he has worked across all levels of the NHS.

Eleanor Grey KC is one of the most experienced practitioners at the Bar in the field of inquiries, reviews and investigations.

During the session we covered lessons that can be learnt from NHS Governance Reviews and common themes and parallels in organisations that fail. We also covered the state of play of ongoing current inquiries and their recommendations.

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How we can help

Browne Jacobson have a very experienced Inquiries team and would be happy to discuss your needs on dealing with inquiries/investigations and their recommendations. Our team have worked with clients on these matters for many years and are currently working with clients on areas such as:

- Support during an investigation or inquiry, this covers both those who have core participant status in a public inquiry and those who do not.
- Advising on terms of reference and governance processes for independent inquiries and investigations.
- Advice on complying with data obligations and enabling a full and thorough process to be undertaken which is fair to all, including how to manage a Maxwellisation process.
- Working with clients to understand recommendations which they need to implement and mechanisms that can be used to embed recommendations and assure the Board that this has been properly done.
- Providing ad hoc advice to clients on all issues which can arise over inquiries in all their shapes and forms.

Through all of our work we aim to provide strategic solutions and advice to clients.

Background

Gerard Hanratty – Partner
Browne Jacobson

Public inquiries generate a substantial volume of recommendations, and many questions are asked as to the extent to which these are actually implemented. When acting for public sector clients who are subject to a public inquiry, one of the first questions lawyers ask is how they can show that previous recommendations have been implemented. If they haven't been implemented, public bodies will be expected to explain why

How public bodies can demonstrate implementation and compliance with recommendations is an important topic. A recurring theme of public inquiries over the last 24 months is that people don't know how many recommendations have been made and what they are.

In the ongoing Thirlwall Inquiry, the Inquiry are looking at healthcare recommendations from other investigations and public inquiries to see if they have been implemented and, if so, what impact they have had. The themes from the Thirlwall Inquiry include:

- Improving patient safety.
- Improving NHS culture and governance.
- Improving the ability to raise complaints and concerns.
- Regulation and oversight of NHS managers.

In 2022 the NHS was the seventh largest employer in the world, with about 1.4m employees. How you go about changing culture in an organisation that big is a significant challenge.

Even without looking at public inquiries, there are a lot of recommendations coming down the line. There has been the Rapid Review into data on mental health inpatient settings by Dr Strathdee and we are waiting for Dr Penny Dash's final comments regarding the operational effectiveness of the Care Quality Commission. There has also been the outcome of the independent investigation of the NHS in England led by Lord Darzi and a multitude of local reports, and recommendations.

Big public inquiries which will generate a wide range of recommendations include the Covid Inquiry, Thirlwall Inquiry, Lampard Inquiry and the David Fuller Inquiry.

These inquiries are likely to generate a multitude of recommendations, and in terms of implementation, a key question is whether there is a process in place in an organisation that actually looks at the recommendations and works out how to deal with them. Public bodies need to ask what their governance arrangements are to ensure that they implement the recommendations. Another key question when recommendations are made, is who determines the risk rating that applies to them. Recommendations can't all be implemented at the same time, so who decides the order in which they are implemented and when is another consideration for organisations. There is also the question of having a board assurance process. It is important that the board is aware and conscious of the recommendations. Public bodies should consider whether their governance model needs to change and adapt to embed implementation and assurance.

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Lesson Drawing from NHS Governance Reviews

Moosa Patel – Director
Office of Modern Governance

Moosa shared a case study of a review in Liverpool in 2013 which remains relevant as many of the issues which came out in that review have subsequently been repeated in others. The review drew out some key lessons, in particular how organisations can end up in difficulties from a place where they had thought they had good governance mechanisms.

Moosa highlighted how in Liverpool there was a seemingly really robust governance structures in place with plenty of examples of what would be considered constituted good governance. Their risk escalation was good, as was engagement of staff through surveys and feedback. However, there was a really single-minded board focus in achieving Foundation Trust status at the expense of everything else. This took the organisation down the wrong path as they cut services, for example reducing the district nursing workforce by 50% without anyone on the board asking what the impact of this would be on services or staff. It was revealed that the board was really inexperienced and very much led by an executive who ran the organisation at the expense of non-executive board members.

The key lessons drawn from Liverpool were:

- How an organisation can lose its way quickly and how a board can fail to spot the early warning signs that could have averted a crisis.
- How in a singular drive and focus to achieve a narrow objective, the board can become unsighted to the concerns of staff and patients.
- The Board failed to appreciate the enormity of what was happening, reacted too slowly, if at all, to matters of concern of which they were aware, and downplayed the significance of others.
- It highlights that good governance is at the heart of an effective health care organisation, but that this is only as good as the people who work in the organisation.
- At its core this is therefore about having an effective board, who understands its role, who challenges, provides insight, triangulates, attends to culture, and has an effective programme of work at board and committee level, alongside an embedded governance model and a robust programme of board development.

Moosa explained that, when you take a broader view on why certain organisations fail, there are many parallels when you look across sectors, which often start from the board. Common reasons why organisations fail include:

- Lack of board and committee meeting structure.
- Failure to follow process.
- Lack of strategic focus.
- Getting wrapped up in minutia.
- Not using the right data and information for reporting or forecasting.
- Not sufficiently forward focused.
- Lack of diversity and experience.
- The dominance of personality, group think, and the absence of conflict.
- Bickering, especially where there is a focus on personality.
- Not effectively holding management to account.
- Failing to deal with or tolerating underperformance.
- Failing to attend to the culture of the organisation.

In building a forward-looking board that avoids the factors common amongst failing organisations, Moosa highlighted some key actions:

- Invest in a well-resourced corporate governance function that acts as the conscience of the organisation.
- Adherence to governance processes.

- Presence of dynamic board and committee work programmes.
- Ensure a clear line of sight to the board.
- Focus on poor performance and do not just accept it as the norm.
- Attend to the culture of the organisation
- Board triangulation using multiple platforms and board oversight of culture by having deep antennas into the organisation.
- Regular review of board skill mix and robust board succession plans.
- An ongoing programme of board development that facilitates the creation of a board typified by openness, trust, and collaboration.
- Take a periodic independent look at your governance.
- Governance needs to remain dynamic. Look outwards for solutions and new thinking.

Office for Modern Governance website

Inquiries and their Recommendations – What's Happening Now?

Eleanor Grey, KC
39 Essex Chambers

Eleanor discussed how recommendations are designed and framed when they are put in place.

Thirlwall Review

The ongoing Thirlwall Inquiry has generated an 850 page document listing the various recommendations made in the healthcare sphere, going as far back as 1967 and ending with IICSA in 2022. The Inquiry put together a table with comments from DHSC and the absence of "green" entries, which was evidence of implemented recommendations, was striking. While the core participants in the Inquiry argue that implementation is considerably better than the table shows, even if that is correct, it demonstrates the difficulties in tracking the implementation of recommendations.

House of Lords

The House of Lords has recently published a report into the Inquiries Act 2005.

The report focuses on the damage done to the credibility of investigations if recommendations aren't implemented and, crucially, seen to be implemented. Victims have become increasingly outspoken about the track record of implementation and have voiced criticism of various institutions subject to public investigations.

The House of Lords report looks at how inquiries can be better designed for accountability and catharsis. The report recommends a new Parliamentary oversight committee to look at recommendations and act as a tracker to assist transparency, as well as conducting thematic research and meta-analysis of recommendations common to multiple inquiries.

HSSIB: barriers to implementation

A report by HSSIB revealed the untenability of the current situation where public bodies on the receiving end of recommendations feel swamped.

Often these bodies are faced with recommendations with considerable overlap and no sense of prioritisation. This problem needs a pragmatic solution from the top and a programmed approach to implementation.

Another issue that is frequently encountered by lawyers working on inquires is criticism of the structure of recommendations. Often there is no real guidance or assistance offered. An inquiry will make a set of high-profile recommendations but will not have tracked the record of policy recommendations previously implemented. Resolving this requires a collaborative approach, with cost benefit analysis of previous recommendations conducted before new ones are issued.

Inquiries like to ground themselves in standards. They want to measure what is happening on the ground against those standards to test implementation. Public bodies subject to inquiry must therefore be able to demonstrate compliance in a difficult and complex landscape. We could be moving into a period where we see a trend of fewer inquiries but more focus on implementation of recommendations. The key question will be what the barriers to implementation are and, given that the track record is so difficult and contested, what would help those on the ground to be able to secure more focus on implementation.

Discussion

There was discussion around how sometimes there is a sense of impunity at senior level, with disproportionate frameworks that regulate junior staff, which are not replicated with senior ones. The question was raised of whether executive frameworks are needed to hold senior managers to account.

It was noted that this is a huge hot topic in the Thirlwall Inquiry and it is likely that recommendations are made on the regulation of senior management. There was discussion on the potential unintended consequences of further regulatory structures, the demand on time it would cause and the importance of looking carefully at the impact of regulatory requirements.

Discussion touched on the regulatory frameworks already in place, such as the Well Led Framework, which NHS organisations must adhere to. While there are measures already in place about board and senior leadership, it was noted that the issue is that so few organisations undertake reviews internally or externally, it is difficult to get insight into whether they are meeting the established standards. The challenge of post-incident reporting was also discussed and how interventions can be made before the stage at which things go wrong.

Discussion also focused on how multiple national reports can present organisations with an overwhelming volume of recommendations to action. The sheer quantity can mean that there is a risk of duplication and one recommendation being slightly at odds with another. It was noted that coroner reports often require an organisation to do something that is not aligned with a national policy or recommendation. A big issue is how to join up and work local recommendations with the national ones.

The question was raised of whether organisations now need to employ people to specifically look at recommendations and follow them through to implementation. It was noted that safeguarding boards will often issue what they think are good recommendations, receive assurance on implementation, but then when they look more closely it is a completely different picture on the ground.

It was asked whether we have now got to a position where there was a hierarchy of recommendations coming through. If a board is focused on a specific objective, does that have an impact in prioritising certain recommendations or fitting those recommendations around the existing view an organisation has. There have been many occasions where an organisation will put together an action plan that does not necessarily address the recommendation. Rather, the organisation is trying to retrofit what it is already doing around the recommendation.

Finally, the discussion touched upon the stories from victims in the recent Grenfell and Post Office inquiries from a societal perspective and the perception that nobody is held to account, with senior leaders often going on to better positions, leaving those affected with trauma. Taking a systems approach in terms of something going wrong and looking at it from a board perspective can mean nothing to those with trauma if they do not feel as though justice has been delivered. People want to see that justice and the question is how to create a system where people are heard.

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