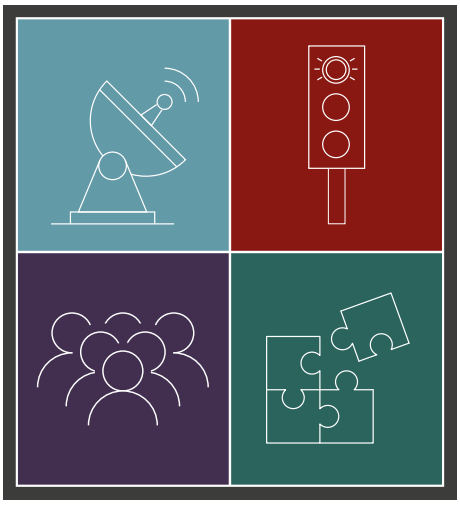
Recognising and responding to early warning signs in public sector bodies

A review by the Committee on Standards in Public Life

The Committee on Standards in Public Life



March 2025

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Chair, Doug Chalmers CB DSO OBE

March 2025

Chair's foreword

Grenfell, Windrush, Infected Blood, Post Office Horizon IT: each scandal very different in nature, but all with a catastrophic impact on human lives.

It isn't hard to find common themes among these scandals – a failure to listen to and act on concerns raised, a failure to learn lessons from similar incidents, and a failure to identify and share emerging risks.

Of course, hindsight is an unforgiving prism through which to view past decisions made in complex environments. But there is value in taking a step back and asking why so many of the same themes come up time and again in public life and to consider whether there is more that public sector bodies can do to spot problems at the earliest possible stage – while there is still time to act and potentially avert a disaster.

That is the task we set ourselves for this review. What did we find? That there are things organisations can do to increase the likelihood of risks and issues being uncovered. That culture and leadership, at all levels, are central to ensuring that these processes are effective. And that building an organisation where it is second nature for people to speak up about concerns is an art and not a science. By this I mean that there is no blueprint to follow, but when leaders are committed to advocating the benefits of an open culture and listen with curiosity when staff raise concerns, or suggestions for better ways of doing things, organisations can catch risks or make improvements and, as a result, are better able to deliver their purpose in the public interest.

It is not always easy to speak up – it requires moral courage to be the person who says, 'I'm not sure this is going to plan,' or, 'is there a risk that if we do X, it will have these negative consequences?' But in doing so, we honour the basic contract that we as holders of public office have with the public we serve.

Readers of our reports will notice that we revisit and expand on some of the themes we first discussed in our 2023 report, 'Leading in Practice', as well as exploring new areas. We share the same aspiration that we had for Leading in Practice, that this report will stimulate discussion and be a useful resource for leaders in the public sector as they reflect on how they can best equip their organisations to identify and resolve problems or issues that might get in the way of delivering the core purpose of their organisation. With this in mind, we have included 20 points for reflection to assist leaders and which employees can use to hold their leaders to account.

Doug Chalmers CB DSO OBE
Chair, Committee on Standards in Public Life

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Executive summary

The common themes among organisations that have failed the public in recent years are clear for all to see.

Many of the reports of public inquiries and other independent reviews have revealed weaknesses in organisational culture, characterised by defensiveness and a reluctance to listen to and act on concerns raised by employees and members of the public. There was often a failure to identify and address emerging issues before they escalated and a failure to learn from previous mistakes or similar incidents and failures.

While addressing failures in public life requires clear and unambiguous law to sanction misconduct, it is equally important to focus on what public sector bodies can do to stop these failures from happening in the first place.

The purpose of this review is to support public sector bodies to put in place the processes needed to recognise the early warning signs of emerging problems and to facilitate a culture where speaking up about concerns and learning from mistakes are seen as a personal duty and are valued by everyone in the organisation. Our aspiration is better outcomes for the public by mitigating the risk of harm, saving taxpayers' money and leading to the more effective delivery of public services.

We include examples of how organisations have sought to identify and respond to the early warning signs of emerging problems and have identified **20 points for reflection** which we hope will assist leaders to consider whether improvements can be made to their organisations' processes and culture, and which employees can use to hold their leaders to account.

Chapter 1: The Principles of Public Life and the public interest

The Principles of Public Life – honesty, openness, objectivity, selflessness, integrity, accountability and leadership – require holders of public office to act solely in terms of the public interest.

The public interest should guide the actions and behaviours of public office holders at all times. At the most prosaic level, pursuing the public interest means getting the basics right and providing a good service. Public bodies must be cognisant of the power imbalance between them and the users of their services and should be approachable and responsive when people have cause to complain.

Acting in line with the public interest is an obligation. But it also offers huge benefits. It promotes public trust, which, in turn, is necessary for compliance, supports good decision-making in complex and fast-moving situations and builds a culture where the workforce is unified by a common purpose.

Chapter 2: Accountability within the delivery chain

Public service delivery is complex, which is why it is crucial that there are robust accountability mechanisms running through each delivery chain. The specific mechanisms and processes will vary between organisations and sectors but there are four basic characteristics that should be common to all organisations:

1. A clear governance and accountability structure.
2. A well-defined set of objectives.
3. Effective systems for monitoring performance, finance and risk.
4. A strong and active sponsorship relationship between organisations in the same delivery chain.

This chapter explores these factors with reference to the relationship between government departments and their arm's length bodies (ALBs). We share examples of best practice with the intention that they will be of assistance to departments and their ALBs as they work together to deliver public services in the public interest. In particular, we include examples of how departments ensure an ongoing dialogue with their ALBs about the ALBs' objectives and examples of the methods used by departments to gain assurance about their ALBs' management of risk and performance.

Building strong relationships based on trust matters. When these relationships work well, they enable effective accountability. The importance of sponsorship can sometimes be underplayed within departments. Effective sponsorship can help to identify and address risks and potential problems before they escalate.

Chapter 3: Risk and data

Successful organisations are effective at managing risk. This does not mean that all risk can or should be avoided, rather it means that controls should be put in place to manage risk, to the tolerance level agreed by the senior leadership.

Everyone within a public sector body has a responsibility to identify and report risks. People working in public-facing roles often see the first signs that there may be an emerging problem in the delivery of public services. It is therefore crucial that frontline workers and their managers have processes in place that enable them to identify potential issues. Creating a culture where people feel safe to speak up is a core part of an organisation's ability to identify and act on risks.

Bringing together high-quality data and interpreting it intelligently allows links to be made across the records held by an organisation and can enhance understanding of the risks it carries. Organisations need analysts who can triangulate data and spot trends, but they also require leaders to be curious about what the data is saying about their organisation and, as one of our contributors put it, to "poke in the dusty corners".

AI has the potential to support risk management, given its capability to process huge volumes of data at speed. On the evidence that we heard, the use of AI to help public sector organisations with understanding the risks to which they are exposed is at an early stage.

However, it is crucial that wherever AI is procured, deployed and monitored, it is done so appropriately and in line with the Nolan Principles of openness, accountability and objectivity. Our 2020 report on AI and Public Standards contained recommendations about the safeguards and standards required as AI becomes adopted more widely across the public sector.

Chapter 4: Effective scrutiny by the board

There have been many high-profile failures in public life, where the governance structures and mechanisms were in place but for a variety of reasons the board failed to grasp the significance of red flags and failed to act before it was too late.

The quality and timeliness of the information to which a board has access and the thoroughness with which it exercises its challenge role are critical to the exercise of the board's scrutiny function. Providing effective challenge means asking difficult questions constructively.

We heard how a breadth of skills and experience on a board can mitigate the risk of groupthink. Equally, refreshing membership of boards by setting limits on the length of tenure or staggering appointment terms can ensure a board remains responsive and alert to new issues. Considering values and motivation at the recruitment stage helps with the appointment of people with a public service ethic and sends the message that how board members go about their work will be considered central to the delivery of their role.

The culture of the board is a crucial factor in its effectiveness and will be heavily influenced by the quality of the relationships between and among the executive leadership and non-executive directors.

Bringing an independent, external perspective to board meetings and hearing directly from the users of public services enhances insight into the organisation's delivery of its services.

Chapter 5: Being open to public scrutiny

Making information available about what an organisation does and how it does it enables the public and those bodies charged with holding the organisation to account to scrutinise its performance and expenditure. Withholding information merely to protect the institution (or its members) from scrutiny does not meet the Nolan Principle of openness.

The more power an organisation has over citizens' lives, the more transparent it needs to be about what it is doing and how. Meaningful transparency also requires that information is presented in a manner that is clear, intelligible and, where appropriate, in context so that the full significance of the information can be understood.

Good records management is a prerequisite for an accountable organisation. It means that information about why decisions were made is preserved should it be necessary to

review these decisions in the future. The contemporaneous nature of the record provides some assurance that it is an accurate reflection of what happened. Documenting decisions accurately also enables organisations to learn lessons when things go wrong and to evaluate comprehensively the success or failure of projects or policies.

Accountability requires bodies to be approachable and to make it easy for people to raise issues with them. It also requires organisations to engage proactively with the public to increase understanding of how they can best meet their needs.

Parliament, ombudsmen, regulators and inspectorates all have a role in scrutinising public sector bodies and holding them to account for their delivery of public services. Public sector bodies need to support these scrutiny bodies in their task by being responsive to requests for information and by seeing them not as a threat, but as a provider of constructive challenge and a source of insight about how they can be better.

Chapter 6: Learning from successes and failures

Failing to make time to ensure that lessons are learnt when things go wrong may mean that opportunities to avert subsequent disasters are missed.

Organisations need to have processes in place for reviewing scenarios where things do not go according to plan, identifying the lessons that can be learned and then ensuring that these lessons are embedded within the organisation. Public sector bodies should also take note of recurring themes when things go wrong elsewhere in public life and consider what their own organisation might learn from these crises.

Putting the public first also requires public office holders to share learning when projects, policies and procedures work well so that these successes can support improvements in public service delivery elsewhere.

Complaints can provide valuable insight for an organisation into how the public is experiencing its services and flag issues that warrant closer investigation.

Whether complaints are viewed as an opportunity or a threat is determined by the tone set by the leadership of an organisation. It requires leaders to value and prioritise the learning to be gained rather than resorting to blame, defensiveness and reputation management.

Chapter 7: Leadership and culture

It is clear to us that leadership is the most important factor in an organisation that successfully identifies and addresses emerging issues promptly and is willing to learn from its mistakes.

Clarity. Leaders must be clear that they welcome potential problems being brought to their attention early and that everyone in the organisation has a duty to deal with the public with openness and honesty.

Consistency. Leaders must be role models for the standards they expect of others, even when they are under pressure. When employees speak, leaders must listen.

Consequences. Leaders must address behaviour that is inconsistent with a culture that values people raising concerns. In public life, the 'how' is as important as the 'what' in getting things done.

This chapter discusses existing duty of candour obligations in public life and the government's commitment to legislate to introduce a duty of candour for public servants.

We have seen in the reports of independent inquiries how, when the public has suffered as a result of action or inaction by a public sector body, it is often the defensive response of the body and its failure to admit where it went wrong and apologise, that compounds the pain suffered by those affected by its actions. When public officer holders make mistakes, they must acknowledge the failure and offer a meaningful apology.

An organisation that approaches public scrutiny openly and transparently, does not seek to defend the indefensible and treats the public with respect, needs an open internal culture that supports employees to speak up if they become aware of actions or behaviours that are falling short of these standards.

Employees need to feel that leaders are genuinely interested in what they have to say, and leaders need to be visible and available. The way leaders respond when people raise concerns has a ripple effect though an organisation – for good or bad. Strong leadership requires leaders to be curious about their organisation and to welcome concerns and complaints as information that will enable them to make improvements.

While the aspiration is a culture where people feel comfortable raising concerns as and when they arise, formal speak up/whistleblowing mechanisms are a crucial safety net and there will always be a need to have effective and trusted formal processes in place.

Public sector organisations must train their leaders how to handle a crisis appropriately so that they are better prepared when things go wrong and less inclined to minimise problems that are raised with them. Leaders must also actively search out the first signs of issues that may be bubbling under the surface.

Organisations need to be careful not to disincentivise leaders from identifying issues and learning lessons from them. How expectations and priorities are communicated is very important. If it is made clear that leaders will be judged by the way they learn from complaints rather than how they manage them, this approach may have a positive impact throughout the organisation.

One of the perceived barriers to leaders escalating concerns to the organisation at the next level in the accountability chain is concern about that organisation's response. Providing the right targeted leadership and improvement support may help people feel that it is worth raising concerns and asking for help.

Points for reflection

Building accountable organisations

1. How do you support your employees in understanding how their role, and the purposes of your organisation, serves the public?

2. Is it clear to your employees how decisions are made within your organisation and who is accountable for them?

3. What do you do to build strong relationships with those bodies that report to your organisation as well as those bodies you are accountable to?

Identifying and assessing risks

4. How do you know that the arrangements you have in place for the identification and mitigation of risks are effective?

5. How do you assure yourself that the data your organisation collects to assess its activities is of a high quality and that there is sufficient capability within the organisation to interpret the data intelligently?

6. How do you ensure your organisation views complaints as valuable feedback reflecting the public's experience of its service and uses that data to spot systemic issues and make improvements?

Speaking up

7. What do you do to build an open culture where people feel comfortable raising issues, asking questions and sharing their ideas?

8. How do you help your employees to understand that everyone in your organisation has a responsibility to speak up when they see something going wrong?

9. Are there clear and well-understood ways for people to raise concerns formally? How do you know these routes are trusted? How do you ensure that when people speak up, they are protected and not victimised?

Development and performance management

10. How does your organisation support the development of leaders who have the skills and confidence to handle a crisis appropriately?

11. How is listening to feedback and embedding learning incorporated into the process for assessing your organisation's executive and non-executive leaders?

Public scrutiny

12. Is your organisation as transparent as it can be when deciding what information to publish about its activities, including the provision of contextual detail where appropriate?

13. Could your organisation do more to engage proactively with the public and to understand the public's perspectives on how to improve your organisation's public services?

14. When things go wrong, how quickly do you acknowledge the failure and offer a meaningful apology?

Learning lessons

15. Does your organisation have mechanisms in place to support a robust corporate memory of why previous decisions were or were not taken?

16. How do you ensure that the lessons learned from evaluating projects and policies are shared within the organisation and that these lessons inform future decisions?

17. How do you ensure that your organisation regularly considers what it can learn from the successes and failures of other public bodies?

Board scrutiny

18. How do you ensure that your board receives the information it needs about risks and issues in a format that is most useful to board members, enabling them to evaluate the significance of that information?

19. How is your board encouraged to scrutinise robustly the decisions made by your organisation? Is it sufficiently curious? Does it listen to the views of public service users?

20. What do you do to ensure that your board has the right balance of skills, backgrounds, experiences and independence of judgement? Is understanding prospective board members' values and commitment part of the recruitment process?

Introduction

Why this review matters

1. In recent years we have seen a number of catastrophic failures within public life, with a high cost to the individuals affected, the public purse and trust in public institutions. In the most serious cases there has been avoidable loss of life. Chairs presiding over public inquiries into disasters such as the Infected Blood scandal and the Grenfell Tower fire have described in stark terms the catalogues of failures, why they happened and who was responsible.

2. The areas of public life examined by public inquiries and other independent reviews have been varied, yet the reports reveal that many of the same organisational failures were present within the different public sector bodies involved. Many of the reports describe weaknesses in organisational culture, characterised by defensiveness and a reluctance to listen to and act on concerns raised by employees and members of the public. There was often a failure to identify and address emerging issues before they escalated and a failure to learn from previous mistakes or similar incidents and failures. Figure 1 identifies some of the common themes evident in four recent examples.

3. We are not claiming that identifying and acting on these factors would necessarily have averted disaster in each of these cases. Indeed, it is important to read the individual reports to understand each inquiry chair's conclusions and the complex mix of elements which contributed to the flawed decision-making. Instead, we include this table to illustrate the types of factors that are common among organisations that have failed and to which public sector bodies would therefore do well to pay close attention. They may indicate that the initial conditions are present for problems to emerge and grow and for warning signs to go unheeded.

4. The pattern in themes across different cases was echoed in the evidence we took from contributors to our review who had experience of multiple inquiries.

> "What I discovered was that the patterns of behaviour that you are talking about spread across different sectors. Bishop James Jones and I summed that up in the phrase 'the patronising disposition of unaccountable power', which is the report we prepared in 2017.[1]
>
> Those words came from what the Hillsborough Independent Panel found, looking at Hillsborough, but they have recurred in pretty well every scandal that has emerged since we wrote that report in 2017. The Grenfell families contacted us and said, 'In this report, you have written our story.' In East Kent, there were similar patterns of behaviour from the Trust."[2]
>
> **Ken Sutton, secretary to the Hillsborough Independent Panel and secretary to the reviews into maternity care at East Kent Hospitals NHS Trust, 11 July 2024**

1 HM Government, 'The patronising disposition of unaccountable power', 1 November 2017, available at: **www.gov.uk/government/publications/hillsborough-stadium-disaster-lessons-that-must-be-learnt**

2 Department of Health and Social Care, 'Reading the signals', 19 October 2022, available at: **www.gov.uk/government/publications/maternity-and-neonatal-services-in-east-kent-reading-the-signals-report**

5. When major failings occur, members of the public will want to know that those identified as culpable will face consequences. They rightly will want those responsible to be 'held accountable'. But how much better would it be if public sector bodies took steps to mitigate or even prevent such crises from happening in the first place? How much suffering could be prevented? And how much time and money could be saved to spend on public services rather than dealing with the aftermath?[3]

6. The law can punish and it can act as a deterrent. However, for the law to be effective, it must be clear and unambiguous. The Law Commission has identified shortcomings in the offence of Misconduct in Public Office, which it found was outdated and confusing. In 2020, the Law Commission recommended replacing the current common law offence of Misconduct in Public Office, which has existed for hundreds of years, with two offences – an offence of corruption in public office and an offence of breach of duty in public office.[4] It argued these new offences would make the law clearer and easier to follow.

7. We note the government's announcement in the 2024 King's Speech that the government would legislate to introduce a duty of candour for public servants and the Prime Minister has said that the law will include criminal sanctions for those who breach it.[5, 6]

8. The law must be backed up by a culture of accountability. While the principle of accountability is often concerned with how people are held to account for their actions after the event, it must also guide the decisions and behaviour of public office holders in the daily exercise of their roles. Leaders have a responsibility to make sure that the processes and culture are in place to both support the identification and reporting of issues up through the chain of command. They must also respond appropriately to requests for information from the public and those organisations who are tasked with holding the public body to account.

9. The purpose of this review is to support public sector bodies to equip their employees to identify and address problems when they first start to emerge and before they deteriorate into a full-scale crisis. Hence, our focus is on those matters that are within the direct control of public sector organisations. We examine the role of leaders in facilitating a culture where speaking up about concerns and learning from mistakes are seen as

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3 The cost to the public purse when organisations fail the public was illustrated by the whistleblowing charity, Protect, in their report, 'The Cost of Whistleblowing', February 2025, available at: **https://public-concern-at-work.s3.eu-west-1.amazonaws.com/wp-content/uploads/images/2025/01/30100543/PROTECT_Costs-of-Whistleblowing-ONLINE.pdf**

4 Law Commission, 'Misconduct in Public Office', 4 December 2020, available at: **https://lawcom.gov.uk/project/misconduct-in-public-office/**

5 Prime Minister's Office, 'The King's Speech 2024', 17 July 2024, available at: **www.gov.uk/government/speeches/the-kings-speech-2024**

6 Civil Service World, 'New 'duty of candour' for officials will include criminal sanctions, Starmer says', 25 September 2024, available at: **www.civilserviceworld.com/professions/article/duty-of-candour-public-servants-criminal-sanctions-starmer-says**

personal duties and are valued by organisations. This would result in better outcomes for the public by mitigating the risk of harm, saving taxpayers' money and leading to the more effective delivery of public services.

Barriers to overcome

10. Public office holders are dealing with some of the most difficult challenges we face in the UK today, particularly those who work in parts of the public sector that have an impact on the safety and health of the British public. While general policy may be framed at the national, and to some extent, the local levels, the delivery of services on which the public necessarily relies is undertaken by a wide variety of bodies. These bodies include government departments, NHS England, the different police forces across the United Kingdom, councils and executive agencies such as HM Prison and Probation Service and the Driver and Vehicle Licensing Agency. Some bodies such as the Post Office combine public service and commercial goals. These bodies employ a wide variety of personnel – civil servants, police officers, nurses and council officers in addition to the ministers and councillors who determine policy.

11. The size, constrained resources, multiple levels of authority and outsourcing to other bodies all mean that decision-making across the wide span of the public sector is challenging. Errors will on occasion be made and inevitably some things will go wrong. We believe that if people in public office respond quickly to correct errors, learn the wider lessons and apply them to improve public services, the benefit to the public will be considerable.

12. To gain a sense of the barriers to identifying and addressing problems, we asked contributors to our review what they saw as the main reasons that public bodies might fail to act quickly and decisively at the first sign of a problem within an organisation. Given the broad scope of our review, no report could analyse the processes and cultures of individual public bodies. Instead, we have sought to identify themes. Some selected themes that came out strongly were: institutional defensiveness and reputation management, groupthink, poor relationships, fear of speaking up and failure of board scrutiny. Figure 2 discusses their meaning.

13. There are no easy answers and what works for one organisation might not work for another. We hope that the examples and stories we have included will offer food for thought and challenge those working in the public sector to reflect on whether there are barriers to identifying problems within their own organisation and how those barriers might be overcome. Central to this process is keeping at the forefront the primary purpose of the organisation and the underlying responsibility to serve the public interest while nurturing open organisational cultures where problems are reported without fear.

Figure 1: Common themes from recent inquiries

This table identifies themes common to a range of recent inquiries and reviews that contributed to the failure of public sector organisations to identify warning signs and act appropriately. See appendix 1 for some relevant quotations from the reports.

	Theme	Windrush Lessons Learned Review[7]	Ockenden Review[8]	Infected Blood Inquiry[9]	Grenfell Tower Inquiry[10]
1	Failure to listen to and act on concerns raised by employees and/or the public	✓	✓	✓	✓
2	Failure to investigate properly when things went wrong	✓	✓	✓	✓
3	Failure of the board to have effective oversight of issues and concerns	✓	✓		✓
4	Overly defensive organisational culture	✓	✓	✓	✓
5	Failure to support a 'speak up' culture		✓	✓	✓
6	Poor relationships within the organisation		✓		✓
7	Failure to understand the unintended consequences of policy decisions	✓			✓
8	Failure to learn from past mistakes, or similar incidents and failures	✓	✓	✓	✓
9	Failure to identify and share emerging themes that might have alerted the organisation to a developing risk	✓	✓	✓	✓

7 Home Office, 'Windrush Lessons Learned Review', 19 March 2020, available at: **www.gov.uk/government/publications/windrush-lessons-learned-review**

8 Department of Health and Social Care, 'Findings, conclusions and essential actions from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust', 30 March 2022, available at: **www.gov.uk/government/publications/final-report-of-the-ockenden-review**

9 Infected Blood Inquiry, 'The Inquiry Report', 20 May 2024, available at: **www.infectedbloodinquiry.org.uk/reports/inquiry-report**

10 Grenfell Tower Inquiry, 'Grenfell Tower Inquiry: Phase 2 Report. Report of the public inquiry into the fire at Grenfell Tower on 14 June 2017', September 2024, available at: **www.grenfelltowerinquiry.org.uk/phase-2-report**

Figure 2: What are the barriers to identifying, addressing and learning from problems in public sector bodies?

We asked contributors to our review what they saw as the main reasons why public sector bodies might fail to act quickly and decisively at the first sign of a problem within the organisation.

These are the themes that were raised with us.

Institutional defensiveness and reputation management

It can be tempting for leaders to minimise the problems they are presented with and choose to focus on the facts that are more convenient. There can be a cultural disposition to prioritise the protection of the organisation's reputation over addressing mistakes. If problems are routinely denied or explained away, this is at odds with an organisational culture that values people being curious when things go wrong and asking appropriately probing questions.

"We counted eight separate occasions when there were what should have been clear red flags for the trust in East Kent, every one of which they managed to explain away, ignore, think that they had addressed the problem by writing an action plan that was never implemented. The problem went on for at least 10 years."

Dr Bill Kirkup, Chair of reviews into maternity care at East Kent Hospitals NHS Trust and Morecambe Bay maternity services

Groupthink

Groupthink has a number of causes. It can occur when people think the same way because they have similar backgrounds and skills, or when micro-cultures develop due to isolated workplaces that have little interaction with other teams. It can also arise when people are reluctant to challenge or to be seen as an outlier.

"If you look, for example, at leadership teams within public bodies, they tend to be people who think very similarly, people who come from a very similar background and people who will not challenge because they do not want to be the outlier. You always need somebody who will think a bit differently and ask those difficult probing questions to perhaps change the course in which they are going. Bringing some external lens into that leadership group is really important."

Amerdeep Somal, Local Government and Social Care Ombudsman

Poor relationships within organisations

Often scandals in public life are the result of poor relationships. We have seen this in the many reports of inquiries into the failures of maternity services and in the relations between the Tenant Management Organisation and the residents of Grenfell Tower as described in the report of the Grenfell Tower Inquiry.

"The culture which exists in the NHS is informed by ministerial steers, ill-functioning legislation on duty of candour and whistle-blowing, insensitive handling of clinicians by Boards and management and sometimes by the consequences of a hierarchy of clinicians. There are disputes between professions, between clinicians, and between midwives and nurses, and all this gets in the way of listening to patients and patient safety."

Sir Rob Behrens, Former Parliamentary and Health Service Ombudsman

Failure to build a speak up culture

If employees feel that they won't be listened to or supported if they speak up, or that they will be blamed for the problem they are raising, the organisation loses a valuable opportunity to bring potential problems to awareness and resolve concerns before they escalate.

"I do think the most powerful thing you can have is a culture that says it is actually alright to say to your leaders, 'Something is going really wrong here,' or, 'I do not like how this looks,' or, 'Actually, my ward is under-resourced'. That you are not going to get sat on from a height if you do that. To me, that is one of the most powerful things senior leaders ought to be doing."

Mark Fisher, Chief Executive, NHS Greater Manchester Integrated Care Board

Failure of board scrutiny

The board performs an important role in scrutinising the decisions and practices of the organisation. We have seen examples in independent inquiries and reviews where a lack of curiosity or robust challenge on the part of the board meant that opportunities to identify and act on issues of concern were missed.

"Ultimately the final responsibility for an organisation failing should rest with the board, creating a system where oversight stops problems developing at an early stage, and where this fails, the board are then held to account. However, the failings at the Post Office, and repeated failings in the NHS, show the cost organisations can pay where they have weak boards."

Protect, open consultation, submission 20

Chapter 1: The Principles of Public Life and the public interest

1. The primary obligation of public office holders is to the public. Public service is central to the Principles of Public Life, which were set out by the first chair of CSPL, Lord Nolan, in 1995.[11] The principles are: honesty, openness, objectivity, selflessness, integrity, accountability and leadership. Our 2021 report, 'Upholding Standards in Public Life', found that the Nolan Principles have stood the test of time and are reflected in rules and codes of conduct across public life.[12]

2. The Principles of Public Life require holders of public office to act solely in terms of the public interest. Yet the notion of the public interest being front and centre will not have been evident to those who have suffered as a result of the failures of public sector bodies over recent decades – cases such as the Infected Blood scandal, the Post Office Horizon IT scandal, the failure of multiple maternity services and the response to the Hillsborough disaster.

3. In his 2017 report, 'The patronising disposition of unaccountable power', Bishop James Jones called for a substantial change in the culture of public bodies. To help bring about that cultural change, he proposed a Charter for Families Bereaved through Public Tragedy, inspired by the experience of the Hillsborough families and made up of a series of commitments to change.[13] Point 2 commits public bodies adopting the charter to "place the public interest above our own reputation," which explicitly addresses what Bishop Jones describes as one of the core features of the patronising disposition of unaccountable power: "an instinctive prioritisation of the reputation of an organisation over the citizen's right to expect people to be held to account for their actions."

4. Acting in line with the public interest certainly means responding appropriately to public tragedy, but it should also guide the actions and behaviours of public office holders in their day-to-day work. At the most prosaic level, pursuing the public interest means getting the basics right and providing a good service. Most people just want the services they need to be there when they need them. They do not want to feel they have no choice other than to make a complaint. Should a complaint be necessary, organisations need to be approachable and responsive. There is, inevitably, an imbalance between public service users and the body they are dealing with and it is important that public bodies recognise this. That people who try

11 The Principles are referred to interchangeably in this report as the Principles of Public Life and the Nolan Principles.

12 Committee on Standards in Public Life, 'Upholding Standards in Public Life', 1 November 2021, available at: **www.gov.uk/government/publications/upholding-standards-in-public-life-published-report**

13 HM Government, 'The patronising disposition of unaccountable power', 1 November 2017, available at: **www.gov.uk/government/publications/hillsborough-stadium-disaster-lessons-that-must-be-learnt**

to raise issues with public institutions can end up locked in a 'David and Goliath' type battle has been seen vividly in the experiences of sub-postmasters who sought to raise concerns about the Horizon computer system but were wrongly prosecuted.[14]

> "Public service users, however educated and powerful, will face situations where they are heavily outgunned by the public body they are up against. We have to challenge ourselves to make it easier for that person to raise a concern or red flag and for us to provide that route to accountability."
>
> **Rebecca Hilsenrath, Ombudsman and Chair, Parliamentary and Health Service Ombudsman, Joint Association of Chief Executives and Public Chairs' Forum event, 3 July 2024**

5. Acting solely in terms of the public interest is a requirement for all public office holders but being guided by the public interest also offers considerable benefits, both to individuals and to the institutions for which they work.

6. First, public confidence that a public institution is committed to the public interest is crucial for trust in the organisation, which in turn is necessary for compliance. Two examples illustrate this point: the tax system and policing. To take the first, voluntary compliance is at the heart of how the tax system works in the UK. While HMRC has methods and mechanisms to support compliance, high levels of trust, transparency and customer focus are critical to a culture of people paying their taxes. In the second example, the British model of policing is based on the Peelian principles of policing by consent. Those principles recognise that the power of the police to fulfil their functions and duties is dependent on the public approval of the police's existence, actions and behaviour and on their ability to secure and maintain public respect. Damage has been caused in recent years by some very high-profile failings and erosion of standards, but public trust continues to be of critical importance to the operation of the British policing model. Transparency and public engagement are critical to building public confidence that an institution is committed to acting only in the public interest. We discuss these subjects further in chapter 5.

7. Secondly, public office holders are often required to make complex decisions, sometimes in ambiguous and fast-moving operational environments. In such circumstances, taking a step back and viewing problems through the prism of the public interest can help public office holders focus on what really matters. The Principles of Public Life provide a compass to help navigate decisions. Figure 3 features examples of the tools used by public sector bodies to support employees to act in line with them.

14 BBC News, 'Post Office Horizon scandal: Why hundreds were wrongly prosecuted', 30 July 2024, available at: **www.bbc.co.uk/news/business-56718036**

8. Thirdly, we heard compelling testimony that a shared understanding among employees of the objectives that the organisation is there to achieve, and how they serve the public interest, plays an important role in building a culture where people are valued for spotting and addressing potential problems. Tying the culture of an organisation to its purpose can unify a workforce and give meaning to its work. This is in keeping with evidence to the committee's 2023 review, Leading in Practice.[15] Contributors to that review explained how defining organisational values that link to the purpose and mission of their organisation gave the values resonance and had a galvanising effect.

> "Strong connection to purpose is really important. Ideally, colleagues care about the organisation that they are a part of. They care about the customers that they serve, they do not see it as just a transaction. It is important as leaders to set really clear standards and expectations about values and how we do things around here, how we expect managers and their teams to behave to each other. We also have to be really clear about how we expect to deal with our customers."
>
> **Angela MacDonald, Deputy Chief Executive and Second Permanent Secretary, HMRC, 11 July 2024**

9. It is important to note that what the public interest requires in any situation will depend on the relevant facts in each case. Further, the 'public' is not a single homogeneous group – the public is often both the users of a public service and the taxpayer, and the balance between whose needs should have precedence may vary according to the circumstances.[16] But resolving tensions between different dimensions of the public interest calls for active, critical and reflective engagement within the organisation, and clarity about the organisation's core purposes.

10. Ensuring that the public interest is at the forefront when decisions are made within public sector bodies will support high quality conversations and a deeper understanding of the trade-offs that are part of public life.

15 Committee on Standards in Public Life, 'Leading in Practice', 24 January 2023, available at: **www.gov.uk/government/publications/leading-in-practice**

16 Committee on Standards in Public Life, 'The Nolan Principles: Public Standards, the Public Interest and Public Service', 24 October 2024, available at: **www.gov.uk/government/publications/30th-anniversary-of-the-nolan-principles**

Figure 3: Codes and guidance to support employees to act in line with the Nolan Principles

Board members of NHS organisations are subject to the Fit and Proper Person Test (FPPT) supervised by the Care Quality Commission. Adherence to the Seven Principles of Public Life is included in the guidance for assessing good character.

Care Quality Commission, open consultation, submission 4

The 2024 Code of Ethics for policing sets out the professional behaviours that the public can expect to see from officers, staff and volunteers. It is intended to help police professionals to do "the right things in the right way for the right reasons."[17] The three ethical policing principles: courage, respect and empathy, and public service, draw from the policing principles contained in the 2014 Code of Ethics, which included the Seven Principles of Public Life.

Academy Trusts are required as a condition of their funding agreements with the Secretary of State for Education to commit to uphold the Seven Principles of Public Life. The Academy Trust Handbook provides the overarching framework for implementation of effective financial management and other controls. It states that accounting officers must adhere to the Seven Principles of Public Life.[18] The board chair and the accounting officer must manage personal relationships with related parties to avoid both real and perceived conflicts of interest, promoting integrity and openness in accordance with the Seven Principles of Public Life.

The Chartered Institute of Public Finance and Accountancy (CIPFA) has incorporated the Seven Principles of Public Life into its professional standards and guidance to the local government sector.

CIPFA, open consultation, submission 5

17 College of Policing, '2024 Code of Ethics', January 2024, available at: **www.college.police.uk/ethics/code-of-ethics**

18 Education and Skills Funding Agency, 'Academy trust handbook 2024', July 2024, available at: **https://assets.publishing.service.gov.uk/media/66a3909aab418ab055592dda/Academy_trust_handbook_2024_FINAL.pdf**

The Framework for Ethical Leadership in Education adapts the descriptors of the Seven Principles of Public Life to explain what they mean in the context of educational leadership and sets out a set of personal characteristics or virtues expected of leaders.[19] The National Governance Association's (NGA) Pathfinder Project has supported schools and college leaders to use the framework to navigate through ethical thinking and decision-making. The NGA has integrated the framework into its guidance, publications and professional development.[20]

"I am not sure that we have done anything that has been so positive, especially in terms of one of the results being that adopting this did not add to overstretched workloads. It gave leaders and boards confidence. It gave them permission to have these conversations. It gave us all common language, but it did not add to their workload. That was phenomenally positive."

Emma Knights, then CEO, National Governance Association, 10 May 2024

"We use the Nolan Principles in the training that we give to our staff. We audit against them where we have either been asked to do a specific piece of work in that area, so in behaviour or culture, but also, if we were looking at something like a financial management review that was drawing on the managing public money framework, that would be aligned to the Nolan Principles."

Harriet Aldridge, Chief Executive, Government Internal Audit Agency, 24 May 2024

The Principles of Public Life are core and fundamental to the principles of the Civility and Respect project led by the National Association of Local Councils (NALC), One Voice Wales and the Society of Local Council Clerks.

"The pledge is easy for councils to sign up to and it will enable councils to demonstrate that they are committed to standing up to poor behaviour across our sector and to driving through positive changes which support civil and respectful conduct."

NALC open consultation, submission 16

19 ASCL, 'Framework for ethical leadership in education', 2019, available at: **www.ascl.org.uk/ASCL/media/ASCL/Our%20view/Campaigns/Framework-for-Ethical-Leadership-in-Education.pdf**

20 National Governance Association, 'Paving the way for Ethical Leadership in Education', January 2021, available at: **www.nga.org.uk/media/ylteeeuz/ethical-leadership-report-final.pdf**

Chapter 2: Accountability within the delivery chain

Accountability mechanisms

1. When a member of the public engages with the government, in most cases, they will be interacting with a public body or a private provider delivering a service on the government's behalf. Public bodies may be linked in a hierarchy, with each body being accountable to the body that sits above it. Where companies are providing a service paid for by the taxpayer, there must be proper governance of these outsourcing arrangements.

2. The organisations in a delivery chain have different roles, but a common overarching purpose. For example, NHS England and the Department for Health and Social Care do different jobs but their combined purpose is to support the Secretary of State to deliver the goal of improving the health of the nation.

3. Public service delivery is complex, which is why it is crucial that there are robust accountability mechanisms running through each delivery chain. The specific mechanisms and processes will vary between organisations and sectors and no review could examine them all. Instead, we highlight the following four basic characteristics that should be common to all organisations and explore these characteristics with reference to government departments and their ALBs.[21]

    - A clear governance and accountability structure.
    - A well-defined set of objectives.
    - Effective systems for monitoring performance, finance and risk.
    - A strong and active sponsorship relationship between organisations in the same delivery chain.

4. In selecting government departments and their ALBs to discuss the characteristics of accountable organisations, we are not saying that the system is perfect. We are aware of criticism that the ALB landscape is opaque and that ALBs are subject to insufficient oversight. Lord Maude's 2023 report on governance and accountability in the Civil Service contains recommendations on ALBs.[22] In December 2024 the Parliamentary Administration and Constitutional Affairs Committee announced an inquiry into public bodies policy.[23]

21 CSPL is an arm's length body sponsored by the Cabinet Office

22 'Independent Review of Governance and Accountability in the Civil Service: The Rt Hon Lord Maude of Horsham', 13 November 2023, available at: **www.gov.uk/government/publications/review-of-governance-and-accountability/independent-review-of-governance-and-accountability-in-the-civil-service-the-rt-hon-lord-maude-of-horsham-html**

23 Public Administration and Constitutional Affairs Committee, 'Public Bodies: Inquiry', 13 December 2024, available at: **https://committees.parliament.uk/work/8745/**

5. In this chapter we discuss some of the themes that arose in the evidence and share examples of best practice that were drawn to our attention with the aspiration that they will be of assistance to departments and their ALBs as they work together to deliver public services in the public interest.

Accountability and independence

6. ALBs are administratively classified by the Cabinet Office. While there are three categories of ALBs (executive agencies, non-departmental public bodies and non-ministerial departments), in practice, public bodies of the same classification can operate very differently.[24] Government departments sponsor the ALBs within their remit, supported by advice from the Public Bodies team in the Cabinet Office, which provides guidance to departments and issues the ALB sponsorship code of good practice.[25] There is no statutory framework for ALBs in the UK.

7. We heard how the level of scrutiny and oversight of ALBs practised by departments will vary according to the degree of independence that the ALB requires from government to deliver its functions. Some ALBs are set up to have a high level of scrutiny and oversight, with clear direction set through departmental plans. Regulators usually require a high degree of independence to maintain confidence in their impartiality and tend to be set up to be free from political interference. For example, in the case of the Office for Students (OfS), the independent regulator of higher education in England, while ministers can guide the OfS on its strategic priorities for the sector, the OfS is only required to have regard to this guidance. Furthermore, the OfS is completely independent from government in terms of its operational priorities.

8. When we spoke to ALBs we picked up on a sentiment from some bodies that there has been a shift in the degree of oversight exercised by departments in recent years. A non-executive who has worked in a number of large public bodies over the last six years told us that these bodies felt that "the arm was getting shorter" and there was a greater tendency for departments to micromanage. We were told that this is problematic because it muddies accountability.

24 Cabinet Office, 'Public Bodies Handbook – Part 1, Classification Of Public Bodies: Guidance For Departments', page 8, available at: **www.gov.uk/government/publications/classification-of-public-bodies-information-and-guidance**

25 Cabinet Office, 'Arm's length body sponsorship code of good practice', 23 May 2022, available at: **www.gov.uk/government/publications/arms-length-body-sponsorship-code-of-good-practice/arms-length-body-sponsorship-code-of-good-practice**

A clear governance and accountability structure

9. The wide range of ALBs and differences in the intended degree of independence from government mean the governance and accountability mechanisms required will vary. The HM Treasury document, 'Managing Public Money', explains that the terms of engagement between a department and its ALBs should be documented in a framework agreement. This describes the governance and accountability framework that applies between the body and its sponsor department and sets out how the day-to-day relationship should work in practice.[26]

10. The board of an ALB provides leadership, strategic direction, advocacy and independent scrutiny to both the ALB and the department. The Chief Executive of the ALB is usually the Accounting Officer (AO), who has a set of obligations to the Principal Accounting Officer (PAO), who is normally the department's Permanent Secretary. The PAO is accountable to Parliament for the management of public money. Routine oversight of each ALB within the departmental group should be led by a senior sponsor, who is normally supported by a sponsorship team.

11. The Secretary of State is ultimately accountable to Parliament for the performance of each ALB for which their department is responsible. We spoke to Lord Maude, who was commissioned by the previous government to conduct a review into governance and accountability in the Civil Service.[27] Lord Maude raised with us his observation that ministers frequently have little exposure to the work and delivery plans of public bodies and it is unrealistic therefore to expect ministers to be accountable for an ALB's performance. He told us, "There needs to be a much richer connectivity between ministers and the public bodies."

12. Other contributors acknowledged the complexities that exist around the accountability of ALBs.

> "I agree there is a potential accountability gap there, but when you work with good ministers, they accept that it is a joint endeavour and that is what we should be trying to achieve together. They cannot do it on their own. They have to rely on the system underneath them to help them deliver it."
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> **Kathryn Cearns, Non-Executive Director, Nuclear Decommissioning Agency, Joint Association of Chief Executives and Public Chairs' Forum event, 3 July 2024**

26 HM Treasury, 'Managing Public Money', May 2023, available at: **www.gov.uk/government/publications/managing-public-money**

27 'Independent Review of Governance and Accountability in the Civil Service: The Rt Hon Lord Maude of Horsham', 13 November 2023, available at: **www.gov.uk/government/publications/review-of-governance-and-accountability/independent-review-of-governance-and-accountability-in-the-civil-service-the-rt-hon-lord-maude-of-horsham-html**

A well-defined set of objectives

13. A strong ALB has a clear set of objectives articulated by the department. We spoke to a group of departmental sponsorship leads about how their departments communicate objectives and priorities to their ALB. One department, which has a range of different types of ALBs, told us how it takes a proportionate approach to how it engages with its ALBs on priorities and deliverables, with the degree and intensity of engagement depending on the size and nature of the entity and the level of oversight and assurance required by the department.

14. The departmental sponsorship leads described a range of methods, both formal and informal, set out below, that they use to ensure that dialogue around the objectives is ongoing.

    - Ministers send annual chair's letters with ministerial priorities (noting the degree of independence from government in some cases means that this is not always appropriate).
    - Departmental representation on ALB boards.
    - Letter from the senior sponsor to the CEO of the ALB setting out the agreed programme funding.
    - Regular meetings between the senior sponsor and the CEO (with the frequency differing between bodies).
    - Regular engagement with customers receiving services provided by the ALB.
    - Yearly chair appraisal process, some conducted by ministers, some by departmental officials.
    - Sponsor meetings between the departmental and ALB finance and policy counterparts.
    - Ministerial meetings with the ALB.
    - An annual conference run by the department, which brings together the department's ALBs and provides an opportunity to talk through the department's strategic objectives and key priorities.

Effective systems for monitoring performance, finance and risk

15. Outcome assurance, financial oversight and risk management are three of the six key capabilities set out in the sponsorship code (the other three are: agreeing strategy and setting objectives, governance, and accountability and relationship management).

16. Harriet Aldridge, Chief Executive of the Government Internal Audit Agency (GIAA) told us that there is variation in whether departments have appropriate oversight of the delivery risks held by ALBs.

> "If you are looking at the flow through of red flags there is an interesting question around, where significant delivery is done by an arm's length body, whether the delivery risks that that arm's length body holds are making their way through to the central department's risk register. We absolutely see variation in that respect. In some departments audit committee chairs will speak regularly to their arm's length body audit committee chairs and that flow of information up and down is really in place, but there are other departments where there is not that level of engagement at all, and therefore, I am confident that those delivery risks – which really are part of the central department's – are not getting through."
>
> **Harriet Aldridge, Chief Executive, Government Internal Audit Agency, 24 May 2024**

Examples of methods for monitoring performance, finance and risk

17. Set out below are examples of the methods used by government departments to gain assurance relating to their ALB's management of performance, finance and risk.

> "We do an annual assurance assessment, which red-amber-green (RAG) rates the arm's length bodies against a number of criteria, establishing the risk that they present to the department. We ask the bodies for a self-assessment as well. We do not always agree, but we work through the issues and decide on an overall RAG rating as well as individual ratings against those criteria. A paper is then taken to our department audit risk and assurance committee. That allows the risks to be socialised with a bigger group, and we update against those risks on a quarterly basis. If, for example, we think there is a change or digital capability gap, it enables us to connect the right parts of the department with the bodies to try to support them and help them lift those capabilities."

> We have a system of monthly pillar meetings with the relevant team that principally covers risk, performance and finance, but also governance, which is one we are bringing on stream. We also have intelligence streams. There are 16 of those. We find that that is quite effective in terms of getting a sense of the pulse of an organisation. It encourages the team to be factfinders and to be curious. For example, it would include HR, anti-fraud and commercial, and we look at those individually. There is a named lead within the team on that, and we look at those collectively once a month and look for patterns and resonances. As sponsors, we have that cross-cutting perspective that others working on each of those individual areas do not, so we can maybe see patterns that would then collectively constitute what we could judge as a red flag."

> We have policy deep dives. Where we see a risk that looks, from a common sense point of view, as if it might be quite complex, and we want to test the rationale for it and whether the mitigations are right, we increasingly reach out to the relevant [departmental] policy teams and join them up with the relevant policy teams in the body. We convene and participate in that conversation. We also just recently started attending internal meetings of the risk teams and the group leads inside our ALB, so we can understand a bit better their internal process for escalating, and we can take a view as to whether they are making the right judgement calls there."

> In terms of risk, my Deputy Director sits on the board and so would expect any risks to come to the board. Then we have fortnightly meetings with [the ALB] where they would raise risks with us and we would feed them up through the [department] chain."

> [The department] has a central online reporting system for reporting risks, which is managed by our risk team. As well as getting the discussions, every quarter, policy sponsors will update those risk registers for their organisations, which the risk team can then look at centrally to spot any trends across the organisations and, if necessary, escalate that to our senior board in the department. In addition to discussions between policy sponsor teams and arm's length bodies, the risk team and the central team with oversight of sponsorship have introduced regular meetings with individual policy sponsors to discuss risks."

> Our performance and risk committee (PRC) has appointed an independent member who attends the [ALB] risk committee approximately twice a year, so we have that independent oversight. The [ALB] also shares its risk report with us regularly, which we are sighted on as part of the [ALB] board papers, which we receive six times a year. Our senior sponsor attends the [ALB] board meetings as well. In addition, we also have regular meetings with the [ALB's] director of finance, where we discuss risk, finance and governance issues."

> One member of the [department] Audit and Risk Assurance Committee (ARAC) is like an ARAC buddy for [ALB]. They do not formally sit on the committee, but they attend the sponsored body's ARAC meetings. Similarly, we have a lot of interactions with the relevant functional leads for digital risks. We discuss them fairly regularly."

> Our standard practice is to have somebody to be a member of both the [ALB's] board and the audit and risk committee. In that position, I will look at the internal risk register of the organisation alongside the other ARAC members and can therefore help to make sure that the serious things are escalated."

> “The functional capability of the organisations is quite often critical. Whether it is their change capability or HR capability or finance, we have fairly regular forums with the ALB functional lead. The finance directors will come in and meet our finance function. The digital directors will come in and meet our digital function. That is a way of setting standards with functions. What are the department’s expectations of the bodies? Are there capability issues? Are there risks emerging? Can the department lend more support to the bodies? It is about making sure that ALB professions are plugged into our professions.”

A strong and active sponsorship relationship

18. A factor to which departments and ALBs gave equal weight is the importance of building strong relationships based on trust. When these relationships work well, they enable effective accountability. Conversely, when trust breaks down, it is less likely that issues will be exposed transparently at an early stage. A department can act as a critical friend, providing challenge and supporting an ALB to be at its most effective in delivering its purposes.

> “Trust and relationships are so important, so I think as an accounting officer it is my job to have a close, trusted relationship with the chairs and the chief executives of all of my ALBs. I want them to feel able to come to me with any questions, concerns, and advice, and I want them to know that I take an interest and I care about what they are doing. That takes time to build that level of relationship and trust.”
>
> **Cat Little, Permanent Secretary, Cabinet Office, 24 July 2024**

19. A department’s working level relationship with the ALB is held by the sponsorship team, with oversight led by a senior sponsor. It is critical that the sponsorship team really understands the ALB and we heard from a number of ALBs how a lack of continuity, as a result of people moving on within departments, can impact on that depth of shared understanding.

20. We were told that there can on occasion be a lack of alignment between different teams in the same department, which can make ALBs feel they are getting pulled in different directions. One ALB chair told us that ensuring that people from both the departmental finance and policy teams attend meetings with the ALB was an effective way of overcoming this problem.

21. The level at which departments engage with their ALBs is variable. In one department, the sponsorship team has quarterly meetings with the permanent secretary to talk about each ALB. Another department told us how the level of seniority varies. In some cases the senior sponsor is the Permanent Secretary and in other cases it is the Director General, depending on the size of the ALB and the importance of what it is delivering.

22. We heard from departments that ministerial engagement with the ALBs within their remit also varies and is influenced by their level of interest in the entity. Some ALBs told us that they would welcome greater exposure to ministers but had a sense that this was not actively encouraged.

> "Ministers are not exposed at all to what these bodies do, or they are encouraged to think that it is not really their business, and that is wrong too. It is important that the Permanent Secretary as part of his or her duty to the minister should make it possible and encourage it. If ministers do not want to do it, then you cannot make them. It is making it possible that is important. A lot of problems occur because ministers do not know what they can do and what they cannot do. There is often a lack of clarity over what their powers are. They are often discouraged from getting involved with things that they are perfectly entitled to be involved with, and very often should be involved with."
>
> **The Rt Hon Lord Maude of Horsham, 31 May 2024**

23. The importance of sponsorship can sometimes be underplayed within departments. Senior leaders can be very focused on what is happening on the ground and we heard that it is sometimes challenging to get the balance right between sponsorship activity and focusing on matters that are more pressing in the moment. We heard that resourcing constraints mean that sponsorship can sometimes lose out to "shinier and newer programmes and priorities such as digital and AI." Lorna Horton, Deputy Director of the Cabinet Office Public Bodies team told us that departmental sponsorship teams are usually very small, and they often have other responsibilities as well, which then makes it difficult to focus on good sponsorship and the building of relationships. For example, many departments combine their public appointments and public bodies' sponsorship teams. Public appointments can generate more immediate, short-term activity that has to be prioritised, in comparison to the work of sponsorship, which is more long-term activity.

24. When done well, effective sponsorship can help to identify and address risks and issues before they escalate. Success in the sponsorship context may go under the radar, but supporting ALBs, through quiet competence, is of critical importance to departments.

> "You just need to have sufficiently experienced people doing the sponsorship and sitting on the boards and making sure that you have enough resource. That comes down to people knowing what sponsorship is there for and what value it has. A lot of what you do is trying to prevent things going wrong, so it is not always that visible what you have done, but the whole point is not to have a splash."
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> **Departmental sponsorship lead, roundtable, 18 July 2024**

Chapter 3: Risk and data

Risk Management is the co-ordinated activities designed and operated to manage risk and exercise internal control within an organisation.

The Orange Book: Management of Risk – Principles and Concepts[28]

1. This chapter sets out examples that were shared with us of the role of risk management in identifying emerging issues, and the benefits of data in building a deeper insight into these risks. We illustrate the value of maximising the use of high-quality data to enhance understanding of risks across an organisation and look at how AI is starting to be used as a tool to draw together these insights.

2. We do not seek to summarise the key principles of risk management or provide guidance on risk management techniques as these are readily available from professional bodies, specialists and consultants. The first port of call for government departments and their ALBs should be The Orange Book, which sets out the applicable standard for risk management in government.

Understanding and managing risk

3. Successful organisations are effective at managing risk. This does not mean that all risk can or should be avoided, but that controls should be put in place to manage risk, to the tolerance level agreed by the leadership of the organisation. In the case of public sector organisations, the risk appetite will be influenced by the potential impact on public lives and expenditure but also the appetite for innovation in specific areas.

4. Governance in government departments reflects the political environment, with ministers working with the executive and supported by non-executive advisors. Cat Little, Permanent Secretary at the Cabinet Office, told us that while there is variation in how boards at the top of government departments operate, the executive functions of government departments operate in accordance with normal corporate governance standards and are publicly accountable to Parliament through the annual report and accounts process. Every government department sets out their performance on governance and is accountable to Parliament for it.

5. Home Office lead non-executive director, Tim Robinson, set out in the Home Office Annual Report and Accounts for 2023 to 2024 how the department has redefined the Home Office operating model to ensure greater clarity of accountability through the line management chain.[29] Sir Matthew Rycroft, Permanent Secretary at the Home Office, told us how this involved cutting some executive committees, including the Risk and Delivery Committee and instead folding the consideration of risk into each

28 UK Government, 'The Orange Book: Management of Risk – Principles and Concepts', page 57, May 2023, available at: **www.gov.uk/government/publications/orange-book**

29 Home Office, 'Annual report and accounts 2023 to 2024', 30 July 2024, available at: **www.gov.uk/government/publications/home-office-annual-report-and-accounts-2023-to-2024**

element of the department's Outcome Delivery Plan, which is the substance of what the department is trying to achieve. In addition, the Executive Committee looks at performance and risk across the piece in order to ensure that performance and risk are also considered holistically.

> "The thing that we have done, which I would advocate every other department doing, is to have a monthly stocktake between the Permanent Secretary and the direct report, so the Director General or the Second Permanent Secretary, on the basis of a standardised pack of data. It is still relatively early days, but I would say it has made a really big difference. On anything to do with the finance, I hold the chief operating officer to account, or, if it is down the line, the relevant Director General. Each of these stocktakes is structured around six rows: performance, risk, people, finance, our portfolio and commercial arrangements. Those are the six headings, which are accompanied by a standardised set of data. We are measuring changes in the same things each month."
>
> **Sir Matthew Rycroft, Permanent Secretary, Home Office, 16 May 2024**

6. Risk is not a matter that is reserved for senior leaders and boards. Everyone within a public sector body has a responsibility to identify and report potential risks. People working at the sharp end of an organisation, such as frontline officers who come into direct contact with the public, often see the first signs that there may be an emerging problem. It is therefore crucial that frontline workers and their managers have processes in place that enable them to identify and report potential issues.

> "Public bodies should consider what their 'frontline defence' looks like – one core aspect of spotting problems at an early stage is ensuring that frontline managers and middle managers have processes in place to help them identify patterns and problems, which can then be escalated to the senior management team (SLT) as needed."
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> **Northern Ireland Public Sector Chairs' Forum, open consultation, submission 19**

7. Creating a culture where people feel safe to speak up is a core part of an organisation's ability to identify and act on risks. Protect, the whistleblowing charity, told us in their response to our consultation that whistleblowing is one of the best early warning systems for organisations and a key tool to manage risk. In our 2023 report, Leading in Practice, we explored how leaders can create a speak up culture, supported by effective whistleblowing arrangements and we return to this subject in chapter 7.

> "My starting point is that, when something does go wrong, as it did on Windrush, and often elsewhere in organisations, it is never the case that no one knew what was going on. There is always someone who knew. Quite often they are relatively junior, relatively frontline, and feel as though they do not have a voice. They feel as though it is not their job to wave a red flag. On top of the specific things we have done, the cultural change is to make sure that every single person knows that they do have a voice and they use that voice to flag their concerns."
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> **Sir Matthew Rycroft, Permanent Secretary, Home Office, 16 May 2024**

8. We heard that maturity of risk management varies across government. Harriet Aldridge, Chief Executive at the Government Internal Audit Agency (GIAA), told us that she has seen a tendency within government to focus on mitigations that will prevent risk indicators from materialising. This approach can mean corrective action comes too late when things do go wrong. If there was a clearer acceptance at the outset that a major project or initiative is likely to experience setbacks, those responsible would be better equipped to manage the setbacks and ensure the original intended benefits do not become lost. GIAA often sees customers continue with a project or initiative after initial assumptions have changed (e.g. spiralling costs being mitigated by project scope reductions) without properly determining whether the intended benefits remain sufficiently achievable, or whether they could be better achieved in a different way.

9. GIAA has an important role to play in supporting Accounting Officers (both Permanent Secretaries and ALB chief executives) to discharge their responsibilities, but this is not always fully understood. We would encourage Accounting Officers to make the most of this valuable resource.

10. We heard about the checks and balances in place in local government to test how a council is managing its risks. Key internal controls include: appropriate policies and procedures which are regularly reviewed and reflect good practice; regular reporting on performance, finance, risk and project management; internal audit; corporate statutory officers; and overview and scrutiny, audit and standards committees. Heather Wills, Principal Adviser, Finance and Governance at the Local Government Association (LGA), described the complex environment in which local government operates – the challenge of understanding the compound implications of identified risks, within a 'shrinking envelope of finances'.

11. External audit is an important part of delivering accountability and transparency within local government. Councillor Marianne Overton, Vice Chair of the LGA, shared her concern about the delays in external audits, with the system unable to cope with demand.

> "The lack of good external audits, which is just not coping with the volume, is very worrying. It is just not coping at all. The proportion of councils who have had a proper external audit in good time is very small, and that is not good enough. We need to get that right."
>
> **Councillor Marianne Overton, Vice Chair and Leader of the Independent Group, Local Government Association, 14 June 2024**

12. The LGA has developed an improvement and assurance framework for local government that can be used by councils to help them to identify all of the checks and balances and parts of the system that should be supporting councils to identify any issues.[30] All local authorities are required to conduct an annual review of the effectiveness of controls in the organisation and publicly report the findings of this review and the actions they are taking to address areas for improvement in their annual governance statement. Through its guidance and analysis services, the Chartered Institute of Public Finance and Accountancy (CIPFA) also provides tools to support local authorities in their management of risk. CIPFA provides a Financial Resilience Index and a range of statistical data and analysis tools, offering comparators through the Nearest Neighbour Model tool and a Value for Money toolkit that compare costs and performance score against a range of services.

13. Emma Knights, then CEO of the National Governance Association (NGA), told us about the big issues that represent risks for the schools and trusts sector: falling pupil numbers; funding levels; increasing numbers of pupils with special education needs; and challenges recruiting teachers and classroom assistants. She explained how, fifteen years ago, consideration of risk was not something local authority-maintained schools did or talked about but that, with the development of the Multi-Academy Trust system, it is now taken very seriously.

> "Risk management is now absolutely part of the process we would expect to see any board managing, not just on the surface, but with purpose and impact."
>
> **Emma Knights, then CEO, National Governance Association**

14. The Confederation of School Trusts has worked with a group of sector organisations, including the NGA, to develop the Academy Trust Governance Code, which is based on the Charity Governance Code and sets out all of the duties in law and in regulation that apply to trust governance.[31] It starts with the fundamental principle that academy trusts' directors are aware of and accept the Seven Principles of Public Life and that they understand the legal, regulatory and contractual obligations that they must meet, and adhere to the statutory guidance published by the Secretary of State.

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30 Local Government Association, 'Improvement and assurance framework for local government', 24 May 2024, available at: **www.local.gov.uk/publications/improvement-and-assurance-framework-local-government**

31 Academy Trust Governance Code, available at: **https://atgc.org.uk/**

Data

The value of data

15. Bringing together and interpreting data intelligently allows links to be made across the records held by a department. It can provide a level of insight that is more than the sum of its parts. It is not just a tool that is 'nice to have', but a critical instrument for understanding an organisation and assessing its performance and the risks it faces.

16. Failing to identify patterns in the data held by an organisation can have grave consequences. A real-world example can be seen in Baroness Casey's review into the Metropolitan Police Service. The review concluded that the Met's misconduct process did not identify and discipline officers with repeated or patterns of unacceptable behaviour. "We noted the crucial result is that repeated or escalating misconduct is not spotted. The Met therefore misses those who potentially pose the most risk to others."[32]

17. Contributors to our review were clear that the answer to identifying and acting on issues in an organisation does not lie in data alone, rather, it can be an indicator that something requires a closer look. Hard data is one lens but must be combined with soft indicators to maximise insight. We also heard that leaders should not be slaves to data, nor default to requesting more data to defer making a decision. Collecting more and more data points does not in itself provide the answer to complex problems, which requires the application of the right standards and values, along with contextual understanding, in assessing the relevant information. Leaders must be willing to scrutinise what is really happening within their organisation and ask probing questions of the various sources of information to which they have access.

> "Numbers will never tell you anything unless you are curious. It is curiosity and willingness, which is sometimes quite hard as a leader, to go, 'Could this happen in my organisation? Could this be happening here?'"
>
> **Steve Russell, Chief Delivery Officer, NHS England, 24 July 2024**

> "All the systems, processes and data in the world only takes you so far. You just have, as a leader, to have a degree of curiosity about what is going on in your organisation. Poke in the dusty corners, get around, be visible, and try and promote a culture whereby it is the teams themselves who tell you what is going on rather than relying wholly on data."
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> **Mark Fisher, Chief Executive, NHS Greater Manchester Integrated Care Board, 20 June 2024**

32 Metropolitan Police Service, 'Baroness Casey Review', March 2023, page 213, available at: www.met.police.uk/SysSiteAssets/media/downloads/met/about-us/baroness-casey-review/update-march-2023/baroness-casey-review-march-2023a.pdf

Data quality

18. There is a lot of data in organisations, but it is the quality of data and how an organisation makes sense of it that determines its value.

> "One of the essential components to enable good governance is accurate and reliable data. Instead of having a debate about what is happening, you start debating what you are going to do about it. Too often, the discussion in policing is arguing over incomplete data in an inaccurate position rather than saying, 'This is what has happened. This is what we should do about it'. Having accurate data and an accurate picture of what is happening is essential to so many things."
>
> **Chief Constable, Sir Andy Marsh, CEO, College of Policing, 31 May 2024**

19. The Statistics Code of Practice, which sets the standards which producers of official statistics should uphold, is instructive on data quality (one of three pillars on which the code is based, the others being trustworthiness and value). The code outlines the principles and practices that producers of official statistics should adhere to to ensure their data is reliable, accurate and fit for purpose. The data must be relevant, the methods must be sound and the assurance around the outputs must be clear so that statistics are the best available estimate of what they aim to measure, are not misleading and are therefore worthwhile.[33]

20. We heard from the NHS that consistency in reporting of data really matters. This can be improved by increased use of real-time extracts from electronic systems over inputting data second-hand for secondary datasets or data extracts. Real-time data capture reduces error and has obvious resourcing benefits over manual data entry. It also eliminates time lag, which makes it more difficult to identify trends.

> "On the data point, the key message is that, although there is a lot of it, it is about how you make sense of it, how you ensure that there is one source of the truth, because some of the data gets put in manually. What we would like to do over time is to ensure that it comes up through electronic patient records. For instance, when I am visiting all the comprehensive stroke services in the country, we go through the data with them and we always find there are discrepancies between what is reported nationally and what their local data shows. The more we can get to real-time extracts from electronic systems, the better."
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> **Professor Stephen Powis, National Medical Director, NHS England, 24 July 2024**

33 UK Statistics Authority, 'Code of Practice for Statistics Edition 2.1', 5 May 2022, available at: **https://code.statisticsauthority.gov.uk/wp-content/uploads/2022/05/Code-of-Practice-for-Statistics-REVISED.pdf**

21. In a recent cross-government study of data management, the Government Internal Audit Agency (GIAA) identified a relatively immature approach within government departments in terms of the management of data, the quality of data and the way it is shared across government. GIAA has identified only limited examples of predictive data being used effectively.

Examples of the data points available to multi-academy trusts

Finance data. "If the school is overspent – that is often a lead indicator that there is more wrong in the school."

Data on performance and standards. "That data is often lagged data. By the time you get that, things have already gone wrong. You need to know your schools, work alongside your schools and be in your schools. That soft intelligence, the qualitative intelligence, makes a huge difference."

Workforce data. "For example, if you have a good school, which has been securely good, and you suddenly start to see very significant staff turnover, that might be an indicator that all is not well in that school. It will be different for different schools. If you have just taken into your trust a school that has failed its Ofsted inspection, you might expect to see staff turnover. In that case, staff turnover would not worry you. Context matters hugely in your analysis of the data."

Pupil attendance data. "What is the story that attendance data is telling you? More or less, everybody in the Western democracies is struggling with school attendance [post pandemic] If you have a school where you are seeing declining attendance, that would be a cause for concern. You would want to go in and look at what is happening in that school."

"There is a lot of data that trusts will have about their schools. It is about making sure that somebody is looking at the data, trends in the data and where the data does not look quite right or is going in the wrong direction. 'That is unusual'. 'That has not happened before'. Those are important red flags to go and make an inquiry."

Leora Cruddas, Chief Executive, Confederation of School Trusts, 25 June 2024

Data analysis capability

22. To get the most out of the available data, organisations require the capacity to interpret data intelligently. This can be a problem for some organisations who lack analysts who can triangulate data, spot trends and present the data to leaders in a way that enables them to make decisions. The data analytics capability needs to bring all of the information together to determine what is going on in the organisation. Analysis within discrete business areas can lead to more detailed understanding of specific issues but it needs to be brought together to get the full contextual view.

23. Chief Constable Sir Andy Marsh told us how, when he was Chief Constable of Avon and Somerset Police, his team developed a tool that harvested data automatically collected through a 'digital twin' system, creating a data trail that was used to help the organisation, individuals and teams use the insight from the data to learn, improve and solve both organisational and operational problems. The data could also be used to identify the early warning signs of poor performance and corruption, giving the opportunity of intervening early to improve officer wellbeing and service to the public. The system is fed by approximately 30 different databases and includes data such as body worn video activation data, geolocation data, computer use captured through keystrokes, stop and search data, and complaints.

24. Dr Bill Kirkup has led independent investigations into aspects of healthcare, including maternity services. He told us that there is a lot of data in maternity services but very little of it is clinically meaningful. One of the recommendations in his review into maternity services at East Kent Hospital NHS Trust was to introduce a signalling system that was related to outcomes – to allow trusts to compare the way their units were functioning on the basis of a meaningful outcome measure around deaths of babies and severe brain damage to babies.[34] This would allow those responsible for the provision of maternity services to see how they were doing and where they might do better. If they did not take that seriously and act, that would flag a signal further up the chain, so that regulators, like the Care Quality Commission or NHS England, would be able to identify outliers and investigate appropriately. The NHS has committed to developing the maternity outcomes signal system to highlight safety issues promptly.[35]

25. HMRC told us how the department brings together data from a range of sources to identify trends in customer experience and levels of trust in HMRC. They compile a weekly customer insight dashboard for internal use, which includes customers' interaction with digital, telephony and post channels, stakeholder sentiment and social media sentiment. If any worrying trends are spotted, they can be escalated and fixed. The department externally commissions three annual customer surveys for their main customer groups which are published annually on GOV.UK.[36] HMRC also gathers insights and information from the parts of the tax system that operate outside of the department by running a number of stakeholder forums and groups. Angela MacDonald, Deputy Chief Executive at HMRC, told us that when it comes to spotting trends, the

34 Department of Health and Social Care, 'Maternity and neonatal services in East Kent: 'Reading the signals' report;, 19 October 2022, available at: **www.gov.uk/government/publications/maternity-and-neonatal-services-in-east-kent-reading-the-signals-report**

35 NHS England, 'An update on delivery of the first year of the Maternity and neonatal three-year delivery plan and next steps', 16 May 2024, available at: **www.england.nhs.uk/long-read/an-update-on-delivery-of-the-first-year-of-the-maternity-and-neonatal-three-year-delivery-plan-and-next-steps/**

36 HM Revenue & Customs, 'Individuals, Small Businesses and Agents Customer Survey 2023', 30 July 2024, available at: **www.gov.uk/government/publications/individuals-small-businesses-and-agents-customer-survey-2023**

annual cycle can be really important. Methods such as their annual customer surveys as well as their reporting on how the department is meeting its charter standards all provide an opportunity to stand back and assess whether sentiment has shifted over time.[37]

Data-benchmarking

26. We heard how benchmarking is used in different parts of the public sector to compare performance between similar organisations. This can flag areas where performance is below the expected standard but can also identify those organisations with strong performance from whom others may be able to learn. Some examples are listed below:

    - The 'Model Hospital' allows NHS hospital providers to compare how they are performing compared to other providers. It is part of the Model Health System, which is, "a data-driven improvement tool that enables NHS health systems and trusts to benchmark quality and productivity. By identifying opportunities for improvement, the Model Health System empowers NHS teams to continuously improve care for patients."[38]
    - The local government sector has LG Inform, the LGA's data benchmarking platform, which enables council officers, councillors or local authority users to compare any council's performance with any other council or group of councils.[39]
    - The Public Bodies team in the Cabinet Office is developing a Corporate Function Benchmarking resource for the biggest ALBs. The primary aim is for benchmarking to be used by departments and ALBs to ask questions about whether corporate functions could be procured and used more efficiently.

27. The disclosure of data to the public, which can include comparative data between organisations and public service providers, is discussed in chapter 5.

Data-sharing

28. Some contributors told us about the responsibility they have to share data about concerns with other organisations. The Local Government and Social Care Ombudsman (LGSCO) shares information with the Care Quality Commission, Ofsted and other bodies where there is a crossover in remits, when they have a concern that is sufficiently serious for it to be recorded in the LGSCO's decision notice. The NHS comes together with ALBs and regulators to share any concerns they have about services.

37 HM Revenue & Customs, 'HMRC Charter annual report: 2023 to 2024', 30 July 2024, available at: **www.gov.uk/government/publications/hmrc-charter-annual-report-2023-to-2024**

38 NHS England, 'The Model Health System', available at: **www.england.nhs.uk/applications/model-hospital/**

39 Local Government Association, 'LG Inform', available at: **https://lginform.local.gov.uk/**

> "As a publicly funded body we have a responsibility to share what we and only we know. For example, the Care Quality Commission (CQC) has a responsibility for overseeing the quality and standards of social care. We investigate social care. We have a mechanism that wherever we see concerns about social care that are sufficiently serious for us to formally note them down in our decision, we will pass it on to the CQC, we will publish that. We will let the various parties, the body in our jurisdiction, the person who made the complaint and the CQC know that we are doing that. We do exactly the same with Ofsted in relation to children's services. We do the same with any organisation where there is likely to be a crossover and other ombudsmen as well. By sharing information in a timely and useful way is the way that we try to do that."
>
> **Nigel Ellis, Chief Executive, Local Government and Social Care Ombudsman, 10 May 2024**

> "It is important to say that we and others spend a lot of time visiting and getting information. Of course, CQC and other regulators have a statutory role in doing that, and we link in with them very closely. Some red flags and concerns may well come through CQC inspections, for instance, and not just CQC, but also GMC [General Medical Council] and NMC [Nursing and Midwifery Council]. We have mechanisms both regionally and nationally to ensure that we come together as a set of ALBs and regulators to share any concerns we have about services. The alignment with the other regulators is important."
>
> **Professor Stephen Powis, National Medical Director, NHS England, 24 July 2024**

29. The Information Commissioner's response to our open consultation notes that Part 5 of the Digital Economy Act (DEA) creates legal gateways to share information for public service delivery, allowing important data sharing to take place. The response explains that any organisation which uses personal information must protect that information but notes that protecting personal information from harm and unlocking its potential should not be seen as conflicting.

> "Protecting personal information from harm and unlocking its potential should not be seen as conflicting. Organisations who put transparency, privacy and public trust at the heart of their processes will see much more effective results. Especially when using personal information for public service delivery."
>
> **Information Commissioner's Office, open consultation, submission 10**

30. The Information Commissioner's Office's response notes that public authorities should minimise the use of personal information in data collection, publication and analysis. The consultation response from the Royal Statistical Society notes there are ways to make data available for independent analysis while maintaining control over risks to

security and privacy. Examples given are the Secure Research Service currently run by the Office for National Statistics for academic research access to sensitive data produced by government and other bodies, and the deposit of data relating to school examinations in England so that the impact of the grading developed and then withdrawn could be better understood retrospectively.[40]

Can AI help with understanding risks?

31. The use of AI in public life is a particular area of interest for the committee. Our report on AI and public standards, published in February 2020, considered: the risks and opportunities for the Nolan Principles of openness, accountability and objectivity; whether the broader regulatory framework for AI in the public sector was fit for purpose; and the responsibilities of those in public bodies using AI. The report contained recommendations about the safeguards and standards required as AI becomes adopted more widely across the public sector.[41] Since our report was published, AI technologies have been continuing to develop at a rapid pace and governments around the world are grappling with how to harness its benefits while mitigating the risks it presents. In March 2024 we held a seminar with experts to revisit some of the themes discussed in our 2020 report, with a particular focus on how to ensure that public office holders remain accountable for advice and decisions derived from, or made by, AI.[42]

32. Given the capability of AI to process huge volumes of data at speed, we were interested to find out whether AI is yet being used in the public sector to support risk management. During our review, we came across only a few examples of AI being used for this purpose.

> "If the big strength of this technology [AI] will be reading large volumes of data, interpreting them in an artificially intelligent way, and presenting it in a useful form, then it has to be really helpful, particularly for organisations with large transaction workloads. HMRC and DWP are the two classic examples in government. It would be able to give you much more rapid and relevant information about what is happening in their systems, what is happening to the service quality they are providing, preventing fraud, and so on. You can just see how there are many use cases there, given the scale of data that lots of public bodies deal with."
>
> **Gareth Davies, Comptroller and Auditor General, National Audit Office, 24 May 2024**

40 Royal Statistical Society, Data Ethics and Governance Section, open consultation, submission 22

41 Committee on Standards in Public Life, Artificial Intelligence and Public Standards: report', 10 February 2020', available at: **www.gov.uk/government/publications/artificial-intelligence-and-public-standards-report**

42 Committee on Standards in Public Life, 'AI and Public Standards: 2024 AI seminar summary note', 24 May 2024, available at: **www.gov.uk/government/publications/ai-and-public-standards-2024-ai-seminar-summary-note**

33. Steve Russell, Chief Delivery Officer at NHS England, told us that complaints are a really good example of an area where AI tools could be used to identify themes but where this technology is not yet in place.

> "Complaints are a really good example [of an area where AI tools could be used to identify themes]. You can see the numbers, but spotting a pattern and going, 'there has been the same cluster of complaints about these issues or this practitioner over a longitudinal period,' is less sophisticated in most, but not all, organisations. One thing we have been considering is the opportunity to use AI to spot patterns in complaints. I am not an expert in this [area], so I do not know the extent to which it is widely available, although it could be."
>
> **Steve Russell, Chief Delivery Officer, NHS England, 24 July 2024**

34. The consultation response from the Care Quality Commission drew attention to an example of using AI to improve care in a care home from their State of Care report 2022/23.

> **Example of using AI to understand and manage risk in a care home**
>
> Staff at one care home were noticing that large quantities of antipsychotic medicines were being prescribed for people with dementia. When people were distressed and were communicating this through behaviour, there appeared to be little consideration of the reasons why, and so they were given antipsychotics in response. But staff were convinced that these distress responses were a reaction to pain – not because the person had a diagnosis of dementia. The care home therefore worked with developers to pilot a new app that used artificial intelligence (AI) technology to help care staff identify when people were in pain. The app helps the caregiver to recognise and record facial muscle movements and identify other behaviours that indicate pain. It then calculates an overall pain score and stores the result. After it was introduced in 2021, the care home has not only been able to offer more pain relief to people, but there have been fewer conflict-related safeguarding referrals and more time available for staff. Importantly, there has also been a 10% decrease in antipsychotic medicine use across all 23 homes. This has improved the quality of life for people with dementia.[43]
>
> **Care Quality Commission, open consultation, submission 4**

43 Care Quality Commission, 'State of Care 2022/23', 20 October 2023, available at: **www.cqc.org.uk/publications/major-report/state-care/2022-2023**

35. We discussed with the Government Internal Audit Agency (GIAA) the use of AI in providing third-line assurance for organisations. The GIAA has developed an 'insights engine' which allows them to quickly undertake sentiment analysis of a specific area of work to identify themes of good as well as poor practice that can then be shared more widely across government and prompt areas for further investigation.

36. GIAA is also at the early stages of using AI as part of a concept of continuous auditing that involves real-time checking of data against defined criteria. We were told that within this context, it would be possible to train AI to detect a drift towards alert thresholds and the reporting of early warning signs. GIAA is starting to make its AI tools available to other parts of government so that they can also be applied within the first and second lines of assurance. Harriet Aldridge explained that the GIAA's design philosophy for their Insights Engine, and all their AI tools, is that they always have a human in the loop, meaning, "the AI output becomes an input into the analysis of a trained human."

> "Given that it is typically not one big thing that leads to organisational failure, but a series of smaller things occurring in concert, investment in human intelligence continues to be needed to interpret the implications of different indicators veering off track ('joining the dots'). This is particularly the case where confidence in the completeness and accuracy of data is lacking. While AI will help organisations to undertake assurance at greater scale and speed than with a human alone, the effective application of human intelligence continues to be a vital part of the landscape of risk, assurance and controls.
>
> Within three years we expect generative AI to be able to reliably analyse numerical (e.g. financial) data and to create reports that present this analysis in a meaningful way. It will continue to be important to train people to ask the questions (prompt engineering) of the AI. Even where the AI can analyse scenarios taking into account risks, the ultimate decision-making, and therefore accountability frameworks will need to evolve, alongside appropriate training, to ensure decision-makers have sufficient assurance around the inputs and outputs of any AI tool. Whilst larger and more complex in an AI-enabled world, similar principles exist today in the way in which government relies on the integrity of financial models (e.g. actuarial models, operational service demand models and budgeting tools)."
>
> **Harriet Aldridge, Chief Executive, Government Internal Audit Agency, 31 July 2024**

37. One of the core findings of our 2020 report on AI and Public Standards was the importance of public officials retaining involvement in all automated decision-making processes and taking responsibility for decisions made by AI systems. The models for upholding human responsibility can be placed on a spectrum from limited to full responsibility and we said that the senior leadership will have to choose which level of responsibility is most appropriate for the application of AI in their organisation. It is also critical that public sector bodies understand and make available an explanation of an AI system's decision-making process so as to uphold the principle of accountability.[44]

38. Our 2020 report made recommendations to providers of public services, both public and private, to help them develop effective risk-based governance for their use of AI, and which put into practice the Nolan Principles of openness, accountability and objectivity.

39. We discussed with Gareth Davies, Comptroller and Auditor General, the challenges around ensuring human accountability is maintained when AI outputs inform decisions. He suggested that the governance processes for auditing the use decisions would need to be very clear; a standard control that will need to be in place, where the risk is high enough, is to take a sample of the recommendations coming out of the AI system, manually reproduce those decisions using experts, and have a failure threshold that triggers a review of whether the system is operating as intended.

> "This is obviously a developing field, but working through the risks involved, and anything where there are consequences for people of decisions being made by machines, we are going to have to build in a sufficient human check to make sure that it is operating as intended."
>
> **Gareth Davies, Comptroller and Auditor General, National Audit Office, 24 May 2024**

40. On the evidence that we heard, the use of AI to help public sector organisations with understanding the risks to which they are exposed is at an early stage and there is potential for AI to be used more widely for this purpose. However, it is crucial that wherever AI is procured, deployed and monitored, it is done so appropriately and in line with the Nolan Principles of openness, accountability and objectivity.

44 Committee on Standards in Public Life, 'Artificial Intelligence and Public Standards: report', 10 February 2020, available at: **www.gov.uk/government/publications/artificial-intelligence-and-public-standards-report**

Chapter 4: Effective scrutiny by the board

1. Chapter 2 set out that clear governance and accountability structures are an essential requirement if public sector bodies are to be accountable. There must be a defined reporting line through the hierarchy of an organisation, with a clear sight of the risks to which the organisation is exposed. However, there have been many high-profile failures in public life, where the governance structures and mechanisms were in place but for a variety of reasons the board failed to grasp the significance of red flags and failed to act before it was too late.

2. In this chapter we explore four key themes in the evidence we took that seem to us to be fundamental to the effective exercise of the board's scrutiny function, before concluding with some examples of how public bodies have used Board Effectiveness Reviews:

   - **Information and challenge.** Ensuring the board has the information it needs and is willing to ask the difficult questions.
   - **Appointing people with the right skills and motivations.** Populating the board with people with a breadth of skills and experience and a strong public service ethic.
   - **Board culture.** Building an open and trusting relationship between and among the executive leadership and non-executive directors.
   - **External perspectives.** Bringing an independent, external perspective to board meetings and hearing directly from the users of public services.

Information and challenge

3. For non-executive directors to be able to provide constructive challenge to an organisation, they must have good access to information. The responsibility for ensuring this happens is two-way – the executive needs to provide accurate and candid information about the organisation's performance and any emerging issues that may stand in the way of the organisation delivering its objectives, but non-executives also have a responsibility to ask for the information they need.

4. New non-executive directors need to develop a good understanding of the organisation and the risks it is facing and need to do so quickly. Phase 6 of the Post Office Horizon IT Inquiry revealed how, "Many Post Office directors started their roles with an incomplete understanding of the issues facing the organisation. There was an absence of corporate memory, with each director seemingly starting from a blank sheet. Unresolved historical issues only became visible to board members when it was too late." The Institute of Directors has recommended that directors "undertake rigorous due diligence of organisations before they accept board roles. Following appointment, the induction process needs to be systematic and expose them to the history and culture of the organisation."[45]

45 Institute of Directors, 'The Post Office Scandal: A failure of governance', October 2024, available at: **www.iod.com/app/uploads/2024/10/IoD-The-Post-Office-Scandal-%E2%80%93-A-Failure-of-Governance-1-f04f78664e5242c6bebb0a01035806c2.pdf**

5. Contributors to our review told us that how board papers are presented is important, with the issues needing to be clearly and succinctly identified and set out and supported by verbal explanation in board meetings.

> "It is very important that people do not assume reports should be taken as read. It is important that officers in the context of local authorities, or executives in the context of my current employer, take board members through it and identify the salient issues so if they have not read every word, they have the opportunity to at least understand it in summary form. I also think things like reading rooms, where additional data and linked information can be posted, are very useful because sometimes people need to go away, think about it and come back to it. There are all sorts of tools and techniques that you can use to make sure that people get the right information. It is an ongoing challenge because people learn, disseminate, distinguish and assimilate information in different ways. It depends on what sort of a learner you are."
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> **Anthony May, Chief Executive, Nottingham University Hospitals NHS Trust, 24 May 2024**

6. Depending on the complexity of the information and the background and skillset of the non-executive directors, it may be necessary for staff with the necessary expertise to explain what the information means so that the board is able to evaluate the significance of the information they are presented with. In chapter 3 we noted that there is no shortage of data in organisations, but that interpreting the data intelligently can require specific expertise. We also noted in our Leading in Practice report that it is helpful to boards to have data from a range of sources brought together in a way which allows them to connect the dots and understand the bigger picture.[46]

> "It is vitally important that those charged with governance understand the complex information that is being presented to them and that they are in a position to make a meaningful evaluation of it. To aid in this, suitably qualified data analysts or operational staff members should be made available to present complex data to the board to provide clarity and explain what the data means, rather than members being given the information without sufficient context or explanation."
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> **Northern Ireland Public Sector Chairs' Forum, open consultation, submission 19**

7. We heard that the timeliness with which the board receives information is important. One chair of an ALB shared an example where an executive told the chair that the executive had received a report about an issue that they were looking at and they would give the report to the board with the organisation's response once this had

46 Committee on Standards in Public Life, 'Leading in Practice', January 2023, available at: www.gov.uk/government/publications/leading-in-practice

been prepared. “My answer to that is, ‘No, give us the information now. We have to respond properly at the board to that, but I do not want you to hold back. I want you to be willing to give us the information straight away and deliver it.’”

8. To help non-executive directors deepen their understanding of the organisation and to hear perspectives other than those presented by the executive leadership, it can be valuable to make site visits and speak to staff working on the frontline of the organisation.

> “In my experience as a non-executive director, I could achieve very little sitting in a four or five hour trust board meeting looking at reams and reams of grids with red, amber and green squares on them. But, by going out and visiting some wards, some clinics and some theatres, saying to people, ‘What is on your mind? How is it going?’ I found a wealth of information that can make you very curious about where there may be problems beneath the surface.”
>
> **Dr Bill Kirkup, Chair of reviews into maternity care at East Kent Hospitals NHS Trust and Morecambe Bay maternity services, 11 July 2024**

9. Providing effective challenge means asking difficult questions constructively. For organisations in the public sector, an important aspect of this should be testing the ethical implications of strategic or operational decisions or business practices undergoing change and ensuring that the public interest is a central part of the conversations that take place.

10. Alan Kershaw, Chair of the Legal Services Board, pointed out that challenge goes both ways and having executive to non-executive challenge is important too. He also found the presence of apprentices from the Government Board Apprentice Scheme helped challenge the established ways of doing things.

> “I like the executive to challenge the board as well, and that is quite helpful. Recently executive members have challenged me on the way I put some things in an interview, and that is fine. I am very happy about it. I am happy to give the lead of saying, ‘I did not get that as right as I would like to. Let us see how we can all learn from this.’ That is okay. Challenge both ways because they [the executive] know the stuff day-by-day in ways that we do not necessarily. We even have apprentices from the government board apprentice scheme. We encourage them to challenge as well, to ask the extremely naive questions: Why do you do it this way? Why is that important? That makes us think as well. Challenge in all directions.”
>
> **Alan Kershaw, Chair, Legal Services Board, Joint Association of Chief Executives and Public Chairs’ Forum event, 3 July 2024**

11. In a local government context, the full council can be considered to be the equivalent of a council’s board. The National Association of Local Councils told us that councillors must be prepared to ask questions and hold the council’s officers to account for their actions.

"Councillors should brief themselves fully on the contents of the agenda for local council meetings, read council reports and be prepared to ask questions. Councillors must overcome any reluctance to question the clerk or the chair, it is important that councillors hold the council's officers to account for their actions. As soon as new councillors, clerks and chairs are in post they should be offered a one-to-one meeting, offered finance training and have a journey pack."

National Association of Local Councils, open consultation, submission 16

Appointing people with the right skills and motivations

12. A board will be capable of exercising constructive challenge only if its members have the skills and experience necessary to ask the pertinent questions. We heard how a breadth of backgrounds and expertise can mitigate the risk of groupthink, as can refreshing membership of boards through setting limits on the length of tenure or staggering appointment terms.

"You need the competence within the organisation and on the board to spot the red flags. It is having a broader view of the range of competencies you need, both at the executive level, but more importantly on the board. There is no point in having four identikit non-executive directors who are all the same. I would also add to that, a regular churn of non-executive directors, so you do not start to develop groupthink, or think, 'I will not challenge him, because he is a great guy and we have known each other for 12 years while we have been on this board.' You need to bring awkward new faces who will not be worried about upsetting their colleagues and who will ask the open questions and prod the accepted nostrums."

Kate Ellis, Chair, Oil and Pipelines Agency, Joint Association of Chief Executives and Public Chairs' Forum event, 3 July 2024

13. Ministers are responsible and accountable to Parliament for appointments to the boards of public bodies, generally referred to as public appointments. Sponsoring departments are responsible for running the recruitment process for these appointments in consultation with ministers. The Governance Code on Public Appointments says that departmental advice to ministers must include information on the make-up and diversity of the current board and that departments "should ensure there is sufficient opportunity for ministers to engage with the chair of the board the role is being appointed to. Chairs are well placed to advise on the skills and experience needed to ensure the board as a whole is effective."[47]

47 Cabinet Office, 'Governance Code on Public Appointments', 31 January 2024, available at: **www.gov.uk/government/publications/governance-code-for-public-appointments**

14. The chair of a public body will be a member of the Advisory Assessment Panel that assesses candidates for non-executive board members positions and submits appointable candidates to ministers for them to make the final appointment. One chair with experience of being on the board of a variety of public bodies raised the importance of appointing people with the right values and motivations. In interviews for board positions, she questions people about their adherence to the Principles of Public Life and seeks to glean whether they truly understand how to live and breathe the principles in difficult situations.

> "When interviewing now, we spend a lot of time really trying to understand people's motivations, what they think about these things, how do they do the right things, in quite difficult situations sometimes, and try to get them out in an interview. Of course, that is quite hard, but people do develop reputations around that when they become more experienced, which can help. I would say that getting the right people there with the right motivations is one way of getting a good start."
>
> **Kathryn Cearns, Non-Executive Director, Nuclear Decommissioning Agency, Joint Association of Chief Executives and Public Chairs' Forum event, 3 July 2024**

15. We touched on values-based recruitment in our report, Leading in Practice, and encouraged organisations to embed the Principles of Public Life within their recruitment and selection processes. We noted how focusing on values at the recruitment stage also helps set expectations that the public interest should guide behaviour and decision-making and that how board members go about their work will be considered central to the delivery of their role. This is particularly important when appointing non-executive directors who have come from other sectors and may be used to a different operating culture.

> "We would encourage public sector organisations to consider how they can best incorporate within their recruitment and selection processes an assessment of how the personal values of candidates align with the Principles of Public Life, particularly for senior leadership positions."
>
> **Committee on Standards in Public Life, Leading in Practice, January 2023**

16. Several contributors to our review raised frustrations with delays within the public appointments process and the impact this has on securing the best people for the job. We heard that this is a major problem for ALBs and one of the hardest aspects for departmental sponsorship leads in managing the relationship with them. We heard that the process needs to be faster and communication needs to be better for people who have applied and are left waiting to hear if they have been successful.

> "People who are building portfolio careers and want to apply for non-executive director positions will have a number of irons in the fire. They will nearly always have applications in with organisations that are nimbler than the machinery of government, so we find that, quite often, some of our best candidates drop out of the process because it is just so long. Typically, our appointments can take a year, and so we find all the time that good-quality non-executive directors either cannot take the position when it is finally offered or drop out. The chairs are frustrated about that, particularly with roles that require particular professional expertise, such as somebody to advise on digital transformation in a non-executive capacity. We often go down to our second or third choices just because of the time that it takes to navigate the decision points across government."
>
> **Departmental sponsorship lead, roundtable, 18 July 2024**

17. Once appointed it is important that non-executive directors and their organisations invest in their on-going development. To take the health sector as an example, a leadership competency framework for board members was introduced in 2024, which will support the appraisal and development of board members.[48]

Board culture

> "In my experience there are good boards and there are bad boards, in short. The good boards, effective ones, are those that have an open relationship with the chief executive and the executive team. There are no secrets, nothing is hidden, and the board have carte blanche to ask for any information they want so they can really get under the skin of the organisation but are non-executive. The ones which I have seen to be ineffective are those where the relationship between the chair and the chief executive has been dysfunctional. That is when information is hidden from the board and that is when things go very badly wrong. It sounds very basic, but it really does come down to relationships and trust and integrity and openness."
>
> **Amerdeep Somal, Local Government and Social Care Ombudsman, 10 May 2024**

18. The culture of the board is a crucial factor in its effectiveness and will be heavily influenced by the quality of the relationships between and among the executive leadership and non-executive directors. An open and trusting relationship will support the exchange of ideas and perspectives and allow risks to be exposed more quickly, even though conversations will not always be comfortable. How a chair chooses to perform their role really matters to the smooth running of a board. If a chair is too assertive, this

48 NHS England, 'NHS leadership competency framework for board members', 28 February 2024, available at: **www.england.nhs.uk/publication/nhs-leadership-competency-framework/**

can create a climate of fear, which can get in the way of good quality decisions, but a weak chair can be equally damaging. Being an effective chair requires good judgement, strong people skills and a firm commitment to the public interest.

> "We at the Welsh Revenue Authority brought in an external consultant to look at ourselves and decide what people we were and how we operated both individually and collectively as a board. We had two days of doing it, but we decided that this should be done with the executive and non-executive members involved. We learnt an awful lot as individuals, which helped when it got to developing a culture within the board and also from the point of view of getting ourselves in a place where we could challenge in a positive way and move forward as a unit, as they say."
>
> **Rheon Tomos, Non-Executive Director, Welsh Revenue Authority, Joint Association of Chief Executives and Public Chairs' Forum event, 3 July 2024**

External perspectives

19. Some organisations have found they benefit from bringing an external perspective to their board meetings. Examples are the Pension Protection Fund, which has co-opted members on many of its committees with specialised backgrounds, and the General Medical Council, which has co-opted external members of the Audit and Risk Committee. The recruitment of independent co-opted members with specialist backgrounds in areas such as accounting or risk management is strongly recommended by the LGA as a way of supplementing the skills of local government audit committees.[49]

20. Some boards of public bodies have in place mechanisms for hearing directly from the users of their services. The Local Government and Social Care Ombudsman has an advisory forum made up of a majority of members of the public who have used their service.[50] The Parliamentary and Health Service Ombudsman (PHSO) has a Public Engagement Advisory Group formed of members of the public who use the PHSO's services. Both organisations find these bodies enhance executive and non-executive understanding of how the public experience aspects of their service and bring a good source of constructive challenge.

21. In the NHS, many trusts include patient stories at their board meetings, told by the patient or relative or by staff who provided the care. We heard that these can give a powerful and helpful insight into the patient experience, but we also heard a view that it may be tempting to select the stories that show the organisation in a good light.

49 Local Government Association, 'Ten questions for audit committees', 12 April 2024, available at: **www.local.gov.uk/publications/ten-questions-audit-committees**

50 Local Government & Social Care Ombudsman, 'Advisory Forum', available at: **www.lgo.org.uk/information-centre/about-us/public-advisory-forum**

"At every meeting we have a patient story. They are poignant, informative and thought provoking. It is our attempt to make sure we are open to direct access from people who use our services or who we employ, and I think that they are generally well received."

Sir Neil McKay, Chair, Shrewsbury, Telford and Wrekin Integrated Care Board, 4 July 2024

Board effectiveness reviews

22. Board effectiveness reviews (also referred to as board performance reviews) are used by public and private sector organisations to identify and act on weaknesses, including whether the board has the structure, processes, people and performance to deliver its purpose. The Sponsorship Code of Good Practice lists completing an annual board effectiveness review and, at least triennially, an externally-led board effectiveness review, as one of the activities which government departments should require of the ALBs they sponsor.[51] UK Government Investments has issued guidance on the principles that should underpin the board effectiveness review.[52]

23. We asked contributors to our review how public sector bodies should conduct their annual board effectiveness evaluations. The following is a summary of some of the examples and best practice shared with us.

    - The Financial Reporting Advisory Board (FRAB) commissioned the National Audit Office (NAO) to carry out an external board effectiveness review. The FRAB committed to making significant changes as a result and published its action plan for doing so.[53] The NAO cited this as an example of a Board Effectiveness Review making a positive difference.
    - In schools and multi-academy trusts, governing boards are expected to carry out an annual self-evaluation and commission independent external reviews of governance every third year. The National Governance Association (NGA) has developed questions for schools and multi-academy trusts to use when conducting their own reviews.[54]

51 Cabinet Office, 'Arm's length body sponsorship code of good practice', 23 May 2022, available at: **www.gov.uk/government/publications/arms-length-body-sponsorship-code-of-good-practice/arms-length-body-sponsorship-code-of-good-practice**

52 UK Government Investments, 'Board effectiveness reviews', 11 April 2022, available at: **www.gov.uk/government/publications/arms-length-body-boards-guidance-on-reviews-and-appraisals/board-effectiveness-reviews-principles-and-resources-for-arms-length-bodies-and-sponsoring-departments**

53 HM Treasury, 'Financial Reporting Advisory Board effectiveness review: October 2020', 22 July 2021, available at: **www.gov.uk/government/publications/financial-reporting-advisory-board-effectiveness-review-october-2020**

54 NGA, 'Governing board self-evaluation questions', 29 March 2022, available at: **www.nga.org.uk/knowledge-centre/governing-board-self-evaluation-questions/**

- One contributor shared an example of an internal review at a public body. He described three elements:
  - The senior independent director gathered all the non-executive directors together without the chair in the room and had a very open discussion about how the board felt about the way that the chair operated and how the board meetings were conducted.
  - The senior independent director then had individual conversations with the non-executive directors.
  - The non-executive directors were then sent a detailed questionnaire with approximately 35 questions.

  The collective feedback was then compiled into a report to be reviewed by the board.

  > "In my view, the questions were searching. They were not drafted to prevent an opportunity for criticism or constructive challenge. I think that is a good board effectiveness review. It is not the board sitting around for 10 minutes at the end of a meeting and saying, 'We need to do an internal board effectiveness review. Are we all happy with how it is all going?' I think that is self-evident."

- The Northern Ireland Public Sector Chairs' Forum drew our attention to the NI Audit Office board effectiveness good practice guide[55] which contains sample templates for assessing chairs and board members.[56]
- In local government there is no formal requirement to conduct an annual board effectiveness evaluation, although CIPFA told us the annual review of the system of internal control should consider decision-making and leadership arrangements. The scope of the annual review should cover each of the seven principles of good governance in the framework. CIPFA and Solace will be undertaking a review of its guidance for the annual review during 2024 to 2025. In their response to our consultation, LGA told us, "the outcome of this review [annual review of the effectiveness of controls] should be documented clearly and transparently in their [local authority] annual governance statement. Best practice includes ensuring that there has been engagement across the council to inform the review, and that statements are easily understood and accessible to residents, partners, government, external auditors, inspectorates and regulators. Statements should openly and honestly identify issues and remedial actions and provide an update on progress in addressing issues previously identified. The audit committee will review the draft statement before it is finalised, providing challenge to ensure that it is honest and robust. The content of statements should inform the internal audit plan for the next year."[57]

55 Northern Ireland Audit Office, 'Board Effectiveness: A Good Practice Guide', June 2022, available at: **www.niauditoffice.gov.uk/publications/board-effectiveness-good-practice-guide-june-2022**

56 Northern Ireland Public Sector Chairs' Forum, open consultation, submission 19

57 Local Government Association, open consultation, submission 14

Chapter 5: Being open to public scrutiny

1. The Nolan Principle of accountability requires holders of public office to be accountable to the public for their decisions and actions and to submit themselves to the scrutiny necessary to ensure this. Being open to public scrutiny is also central to the Hillsborough Charter, which, in point 6, commits organisations that sign it to strive to "Recognise that we are accountable and open to challenge. We will ensure that processes are in place to allow the public to hold us to account for the work we do and for the way in which we do it. We do not knowingly mislead the public or the media."[58]

2. This chapter explores how public sector bodies submit themselves to scrutiny and shares the examples we heard in our evidence of how they have sought to do so. We focus on matters that are within the control of public sector bodies, widely defined, with the intent of supporting them to live up to the high standards of accountability that the public are right to expect.

Transparency

> **Openness**
>
> Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.[59]

3. Making information available about what an organisation does and how it does it enables the public and those bodies charged with holding the organisation to account to scrutinise its performance and expenditure. The Nolan Principle of openness is clear that information should not be withheld from the public unless there are clear and lawful reasons for doing so. Withholding information merely to protect the institution (or its members) from scrutiny does not meet this high bar.

> "Openness and transparency are not ends in themselves; they empower people, among other things, to hold government and public authorities to account."
>
> **Information Commissioner's Office, open consultation, submission 10**

58 Cabinet Office, 'Hillsborough Charter', 13 December 2023, available at: **www.gov.uk/government/publications/hillsborough-charter/hillsborough-charter-accessible**

59 Committee on Standards in Public Life, 'The Seven Principles of Public Life', 31 May 1995, available at: **www.gov.uk/government/publications/the-7-principles-of-public-life**

> "… self-serving institutional self-protection is not a plausible interpretation of the fiduciary responsibilities that the institutions of government owe to the public and that the principles set out. Derelictions from openness must not be self-serving, and they must not be institution serving; they could only ever be a temporary expedient that calls for a special justification that is able to appeal to the wider public interest, and must, through accountability, be made to that wider public in a transparent way as soon as it is possible to do so."
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> **Professor Mark Philp, Chair of CSPL's Research Advisory Board, The Nolan Principles: Public Standards, the Public Interest and Public Service, 24 October 2024[60]**

4. The more power an organisation has over citizens' lives, the more transparent it needs to be about what it is doing and how. To take policing and health as an example, these are areas where intervention into physical or mental rights or wellbeing require particularly high levels of transparency.

> "I think that there has to be a conceptual change: the more power you hold over a citizen's life, the more responsibility you have to be transparent about why you are doing something and how. It is about understanding the responsibilities of people in public positions who hold public office, be it a surgeon, a doctor, a police officer or a nurse, where you actually have control over people's lives and their bodies in a very physical way and mental way. I think you have to have a different responsibility towards that."
>
> **Baroness Casey of Blackstock, 17 July 2024**

5. Meaningful transparency also requires that information is presented in a manner that is clear and intelligible. It may also need to be seen in context so that the full significance of the information can be understood.

6. Being transparent is not always the easy option. Making available information that is in the public interest, but that does not show the organisation in the best light, can be uncomfortable. It requires strong leadership because such revelations may result in bad publicity in the short term. Leaders who advocate proactive disclosure in these circumstances are setting a good example for their teams to follow and are helping to shape an open and transparent culture. As well as being the right thing to do, being transparent is also a pragmatically wise option, since the information may end up becoming public anyway and being accused of a cover-up can be additionally damaging in the long run.

60 Committee on Standards in Public Life, 'The Nolan Principles: Public Standards, the Public Interest and Public Service', 24 October 2024, available at: **www.gov.uk/government/publications/30th-anniversary-of-the-nolan-principles**

7. It is a requirement under the Freedom of Information Act for Public Authorities in England, Wales and Northern Ireland to make information available to the public. In their response to our open consultation, the Information Commissioner's Office (ICO) drew attention to an open letter that the commissioner sent to public authorities, calling on senior leaders to take transparency seriously. The letter emphasised the need to dedicate resources to improving access to information and to ensuring that the right training, processes and culture are in place. The letter includes case studies that show how organisations have implemented good practice or made improvements in their handling of FOI requests.[61]

> "Transparency is essential if people and communities are to have confidence in the way public services are delivered. Proactive publication is a key to this."
>
> **Information Commissioner's Office, open consultation, submission 10**

8. The ICO told us that the International Conference of Information Commissioners have published 'Principles Relating to Transparency by Design', recognising "the value of Transparency in supporting democratic accountability, good governance, good administration and the effective use of public funds, enhancing public accountability, fighting corruption and maladministration, and in empowering people, enabling their participation in decision-making processes."[62]

9. The Office for Statistics Regulation has issued regulatory guidance on the transparent release and use of statistics and data, informed by the Code of Practice for Statistics.[63] The 2024 Parliamentary Administration and Constitutional Affairs Committee (PACAC) report, 'Transforming the UK's Evidence Base', says this has "helped to unlock important evidence for Parliament, business, researchers and citizens, but there remains more to do."[64] In their report, PACAC also endorsed the recommendation made by Lord Maude in his 2023 report of his review of governance and accountability in the Civil Service that, when a major policy decision is announced, the government should proactively publish the evidence and data underpinning that decision.[65]

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61 ICO, 'Information Commissioner calls for senior leaders to take transparency seriously', 4 March 2024, available at: **https://ico.org.uk/about-the-ico/media-centre/news-and-blogs/2024/03/information-commissioner-calls-for-senior-leaders-to-take-transparency-seriously/**

62 International Conference of Information Commissioners, 'Principles Relating to Transparency by Design', June 2024, available at: **https://home.redrta.org/wp-content/uploads/2024/06/TbD-Paper-WG-approved.pdf**

63 Office for Statistics Regulation, 'Regulatory guidance on intelligent transparency', 2 February 2022, available at: **https://osr.statisticsauthority.gov.uk/publication/regulatory-guidance-on-intelligent-transparency/**

64 PACAC, 'Transforming the UK's Evidence Base, Fifth Report of Session 2023–24', 21 May 2024, available at: **https://committees.parliament.uk/publications/44964/documents/223187/default/**

65 'Independent Review of Governance and Accountability in the Civil Service: The Rt Hon Lord Maude of Horsham', recommendation 32, 13 November 2023, available at: **www.gov.uk/government/publications/review-of-governance-and-accountability/independent-review-of-governance-and-accountability-in-the-civil-service-the-rt-hon-lord-maude-of-horsham-html**

10. We have summarised below some of the examples shared with us of how public sector organisations seek to practise transparency.

- The Parliamentary and Health Services Ombudsman and the Local Government and Social Care Ombudsman publish their decisions on their websites with the names anonymised.[66]
- HMRC publishes complaints data as part of the HMRC Annual Report and Accounts.[67] The Adjudicator's Office provides an independent tier of complaint handling for HMRC and investigates complaints that have gone through HMRC's internal two-tier complaints process, where the complainant remains dissatisfied. Each year, the adjudicator's office publishes an annual report that looks at their own performance and also provides commentary on HMRC's performance. HMRC's response to the adjudicator's annual report sets out how they have learned from customer complaints to improve their services.[68] The adjudicator can publish thematic reports looking at a specific issue, for example, the 2023 to 2024 annual report includes an insight report on how to apply customer circumstances to decision-making.[69]
- NHS England publishes data on areas of high public interest such as monthly cancer treatment waiting times.[70] Professor Sir Stephen Powis, National Medical Director for NHS England, told us that a lot of data about performance is public so people can compare the performance of their provider with those in other locations.[71]
- The LGA told us that councils make decisions based on openly available written advice, and an overwhelming majority of decisions are made in public meetings. The full council approves the annual budget in public and external audit reports and any findings of maladministration are considered in public meetings.
- The Public Bodies team in the Cabinet Office has produced an interactive transparency report of all ALBs of the UK government. The tool brings together data on ALBs to show the landscape as a whole.[72]

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66 Parliamentary and Health Services Ombudsman, 'Decisions', available at: **https://decisions.ombudsman.org.uk/**; Local Government and Social Care Ombudsman, 'Decisions', available at: **www.lgo.org.uk/decisions**

67 HMRC, 'HMRC's annual report and accounts 2023 to 2024: performance analysis', 30 July 2024, available at: **www.gov.uk/government/publications/hmrc-annual-report-and-accounts-2023-to-2024/hmrcs-annual-report-and-accounts-2023-to-2024-performance-analysis**

68 HMRC, 'HMRC and VOA's response to the Adjudicator's Office 2023 annual report', 14 December 2023, available at: **www.gov.uk/government/news/hmrc-and-voas-response-to-the-adjudicators-office-2023-annual-report**

69 The Adjudicator's Office, 'The Adjudicator's Office annual report 2024', 26 September 2024, available at: **www.gov.uk/government/publications/the-adjudicators-office-annual-report-2024**

70 NHS England, '2024-25 Monthly Cancer Waiting Times Statistics', available at: **www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/monthly-data-and-summaries/2024-25-monthly-cancer-waiting-times-statistics/**

71 NHS England, 'Data dashboards', available at: **https://digital.nhs.uk/dashboards**

72 Cabinet Office, 'Public Bodies 2023', 17 December 2024, available at: **www.gov.uk/government/publications/public-bodies-2023**

"One of our objectives was to be an exemplar around transparency, FOI responses and so on, so we hired somebody who was very experienced at running a good FOI system. We said to her, 'Your job is to make sure that we are 100% on all of the measures on freedom of information requests. Our culture is that we provide as much as we can and we get it out quickly.' That has had a big impact over a few years. They won a prize this year for being FOI team of the year. You might say, 'If the NAO cannot do that, who can?' but that did not just happen because we are the NAO. We made it a priority. We keep putting management effort in. The team leader comes along to the management team quite regularly, to give us an update, and we show an interest in whether it is working or not, whether she has the resources, and so on."

Gareth Davies, Comptroller and Auditor General, National Audit Office, 24 May 2024

Records management

11. Good records management is a prerequisite for an accountable organisation. It means that information about why decisions were made is preserved should it be necessary to review these decisions in the future. The contemporaneous nature of the record provides some assurance that it is an accurate reflection of what happened.

12. Documenting decisions accurately also enables organisations to learn lessons when things go wrong and to evaluate comprehensively the success or failure of projects or policies.

13. The Infected Blood Inquiry showed the disastrous consequences that can result from poor record keeping. It found there was no mechanism to ensure that there was a sufficient corporate memory in the Civil Service of why previous decisions were, or were not taken, and the facts that informed those decisions so the reasons behind them could be understood. This weakened corporate memory led to the repeated use of inaccurate, misleading and defensive 'lines to take' first adopted in the 1980s and then used repeatedly by successive governments without an understanding of the facts underpinning them. These lines were either liable to be misunderstood – for example, the unqualified line that there was "no conclusive proof that AIDS can be transmitted by blood or blood products" – or were wrong, such as the assertion that patients had received "the best available treatment in the light of medical knowledge at the time."[73] The report also found that documents had been lost or destroyed.

73 Infected Blood Inquiry, 'The Inquiry Report, Vol. 1', page 215, 20 May 2024, available at: **www.infectedbloodinquiry.org.uk/sites/default/files/Volume_1.pdf**

14. The ICO consultation response to our review states, "Openness and transparency should be seen as core functions on a day-to-day basis, but they are particularly important at times of crisis. Indeed, the FOIA s.46 Code of Practice in force at the start of the covid pandemic made clear the importance of record keeping by public authorities in crisis situations. This included maintaining good quality records in situations where public bodies may "need to explain and, if necessary, justify past actions in the event of a… public inquiry."

15. In his 2022 report 'Behind the Screens', the Information Commissioner carried out an investigation into concerns about the use of non-corporate channels and the risk of key information not being appropriately recorded and retained by ministers and officials.[74] Following a letter from the ICO to her consultation on the Covid Inquiry's terms of reference, Baroness Hallett, the chair of the inquiry agreed to consider the quality of record keeping during the pandemic as part of the Inquiry.

Public engagement

16. How organisations handle queries and complaints from the public speaks volumes about the culture of the organisation and the importance it attaches to the principle of accountability. People working for public sector bodies should be cognisant of the inherent imbalance between the organisation and the member of the public who is coming to them with a concern. Accountability requires bodies to be approachable and to make it easy for people to raise issues with them. As we have sought to emphasise throughout this report, it is also in the interests of the organisation to listen to concerns raised from within and outside the organisation. These concerns provide an opportunity for issues to be dealt with before they get worse and a number of complaints raising similar themes may flag up a systemic problem which can then be addressed.

17. As well as reactive complaints handling, accountability requires organisations to engage proactively with the public to increase understanding of how they can best meet the needs of the public. Baroness Casey noted that when seeking the perspective of the service-user it is important to ask the right question – users should be asked about their own practical experience and views on the system rather than just seeking wider views on how the organisation or system should be run.

74 ICO, 'Behind the screens – maintaining government transparency and data security in the age of messaging apps', July 2022, available at: **https://ico.org.uk/media/about-the-ico/documents/4020886/behind-the-screens.pdf**

18. Contributors to our review from different parts of the public sector shared some examples of how they have sought to engage with the public.

    - Various bodies, such as local councils, NHS Trusts, Integrated Care Boards and the Care Quality Commission hold board meetings which are open to the public. In some cases, the public can ask questions from the floor. In other cases, the body will take questions and commit to reply to the question in writing within a certain period and report it to the next board meeting.
    - Some local authorities conduct budget and financial strategy consultations to provide greater transparency over decisions about spending priorities. These seek the views of the public on the choices to be made, such as whether to turn off all streetlights at midnight.[75]
    - The Parliamentary and Health Services Ombudsman holds roadshows, where they go to different parts of the country to hear the views and experiences of people who access their services.
    - Some sectors have independent bodies which act as the customer voice. Transport Focus provides this role for transport users, making research available about what people think about their experience of the road, rail, bus and tram network.

19. The Institute of Chartered Accountants (ICAEW) told us there is a need for public bodies to make it easier for the public to engage in the work that they do, for example by holding regular online events at which the public can get involved, ask questions and participate in debates. They also called for the inclusion in the public sector of 'formal accountability events' that are a feature of the private sector, such as annual results presentations and annual general meetings, at which boards provide an account to their key stakeholders of their performance and at which stakeholders can ask questions and receive answers on how boards have discharged their duties.[76]

20. When there are failures in public services, being accountable means that leaders need to make themselves available to listen to the people affected. We heard from Anthony May, Chief Executive of Nottingham University Hospitals NHS Trust about how the trust leadership is engaging with the families impacted by the maternity services scandal.[77]

75 CIPFA open consultation, submission 5

76 Institute of Chartered Accountants (ICAEW), open consultation, submission 12

77 BBC News, 'Nottingham maternity review to become UK's largest', 10 July 2023, available at: **www.bbc.co.uk/news/uk-england-nottinghamshire-66151746**

> "At our annual public meeting last year, we invited the families and we said we would be happy to make a public apology. Their view was it was too soon and what we should instead say is that we wanted to build a new relationship with them. That is what we did, and we built our whole day around it. There are systems and processes you can put in place, like making sure it really is a public meeting and broadcasting it, for example, and there are symbolic things that you can do which show that you really mean it. Recently, the families affected by the maternity review have been engaging with a production company to produce a documentary about their experiences. The last time we met them, in a room like this, in a hotel, they asked me whether I would be happy to have a microphone taped to my chest and be filmed throughout the whole meeting. I have to say, the natural inclination of the people that advise me was not to do that, but I did and the chairman of the trust did it with me. That is not a system or a process. It is a symbol that when you say you are going to be open and transparent, you really mean it because that is a stressful thing to do for three hours but we did it."
>
> **Anthony May, Chief Executive, Nottingham University Hospitals NHS Trust, 24 May 2024**

Supporting Parliament, ombudsmen and regulators to hold public bodies to account

21. Parliament, ombudsmen, regulators and inspectorates all have a role in scrutinising public sector bodies and holding them to account for their delivery of public services. The powers, mechanisms and processes for doing so vary and we will not explore these here. One theme that is common to all is the importance of supporting those bodies with oversight and scrutiny responsibilities to do their job effectively. This theme is about leaders needing to be responsive to requests for information and making themselves available to account for their decisions. It is also about seeing these 'scrutiny' bodies not as a threat, but as a provider of constructive challenge and a source of insight about how they can be better.

22. Officials with experience of Parliamentary select committees shared what they have learned about how best to approach Parliamentary scrutiny. Based on their input we have identified some key principles:

- Try to respond quickly to requests.
- Stick to professional judgement and facts.
- Be as transparent as possible within the parameters set by ministers.
- Think of the select committee as an important stakeholder rather than an inconvenience. In addition to public sessions, private meetings allow information to be shared that it would not be in the public interest to disclose openly.
- For major projects, be proactive in holding events in Parliament to build a base understanding among MPs about the project, the benefits and how constituents might be affected.

23. A sector's relationship with its regulators or inspectorates will always be complex, but it is important that it is based on trust. Building trust is a two-way process and requires investment from both sides. We heard that the need to maintain personal relationships can be underestimated and it is important that leaders make time to get to know senior people in regulatory bodies.

24. It is also important to ensure that public sector bodies have sufficient capacity and processes in place to be able to report to the regulator or inspectorate and provide the level of service needed. Gareth Davies, Comptroller and Auditor General, told us that the NAO's job is made easier when organisations have a dedicated person to facilitate the department's work with them who become experts in the NAO's approach and what they need to do the job efficiently. He also identified the value of a mindset that sees a NAO audit as a learning experience from which the organisation can improve.

> "Every piece of our work has an improvement objective as well as an accountability objective, so, as people become experienced in that kind of role, they become helpful in encouraging the teams that we are working with and that we are auditing to make the most of the opportunity. It can sound a bit counterintuitive, but it is a big learning opportunity as well for them and for us. It is helpful to have that mindset in that relationship, and for that reason it is also helpful to have that person experienced in the way the process works."
>
> **Gareth Davies, Comptroller and Auditor General, National Audit Office, 24 May 2024**

25. Investing in engaging with those holding bodies to account naturally extends to independent inquiries. Anthony May, Chief Executive, Nottingham University Hospitals NHS Trust, shared his experience of engaging with the Ockenden inquiry into maternity services. He told us how he put in place a team of people whose job it was to engage with the inquiry team, to build good relationships, and about the approach he took to supporting the review within the organisation and in the media.

> "We have a team of people whose job it is to engage with the inquiry. My job is to make sure that Donna [Ockenden] gets exactly what she needs, when she needs it and in a format that her reviewers can use to analyse the cases and bring out the themes. It is also then my job to make sure that I build and sustain a good relationship with Donna because she has a difficult job to do. My job is to make sure that we respect the terms of reference and respect Donna's role and then lastly, it is about relentlessly communicating in the organisation and in the media that we think this is a good thing. The corporate position is that we welcome it. We think it will make things better for women and families and we will engage positively with it and we will put the resource aside to make sure it is done properly."
>
> **Anthony May, Chief Executive, Nottingham University Hospitals NHS Trust, 24 May 2024**

Chapter 6: Learning from successes and failures

1. It may be tempting for organisations under pressure to meet targets to concentrate solely on them. But making time to ensure that lessons are truly learnt, when things go wrong, pays dividends. We have repeatedly seen, in the reports of inquiries into major public service failures, that not doing so may mean that opportunities to avert subsequent disasters are missed. Putting the public first also requires public office holders to share learning when projects, policies and procedures work well so that these successes can support improvements in public service delivery elsewhere.

Sharing what works

2. There are, of course, many public bodies who share learning and expertise among the sectors in which they operate. Within the government, two examples – whose chief executives we spoke to for this review – are the Government Internal Audit Agency (GIAA), which provides internal audit services and support for the UK government, and the Infrastructure and Projects Authority (IPA), which is the government's centre of expertise for infrastructure and major projects.

How the Government Internal Audit Agency shares best practice

The Government Internal Audit Agency uses a variety of methods to share information across government about best practice: voluntary sharing by departments, sharing based on a formal sharing protocol and thematic reports in which GIAA draws together anonymised material across departments. These cross-government insight reports review risks across departments and agencies and share examples of good practice from which others can learn and improve their own performance. The reports are launched into each department's audit committee and spark discussion about how the material relates to that department and what the committee needs to consider to improve.

The GIAA has an Insights Engine which enables staff in different departments to search a large volume of documents and reports to find and retrieve content quickly and effectively.

3. There is value in reviewing examples of successful ventures in order to distil core principles that can guide future activity. An example of this is the IPA's principles for project success, a short guide for everyone delivering projects and programmes across government, to help ensure that practitioners get the basics right and deliver government projects successfully.

The IPA's eight principles for project success[78]

Principle 1: Focus on outcomes

Principle 2: Plan realistically

Principle 3: Prioritise people and behaviour

Principle 4: Tell it like it is

Principle 5: Control scope

Principle 6: Manage complexity and risk

Principle 7: Be an intelligent client

Principle 8: Learn from experience

"You really have to be clear on what it is that you are trying to deliver as an outcome and not rush to the scope of a thing. Once you have decided on what that outcome looks like and what the criteria for success would be, you have to align everybody to what you are endeavouring to deliver. Then you have to estimate it with accuracy and work out how long it is going to take you, because the starting point is all agreeing on the size of the thing."

Nick Smallwood, Chief Executive, Infrastructure and Projects Authority, 18 April 2024

4. We heard examples from different parts of the public sector where membership organisations with a sector-wide remit seek to share good practice and provide support to public bodies through the training they provide and by bringing together organisations to learn from each other. From the Local Government Association to the Confederation of School Trusts, to the Public Chairs Forum, these organisations perform an important role in connecting and professionalising their sectors, ensuring that experiences are shared and best practice is promulgated.

Learning lessons when things go wrong

5. Organisations need to have processes in place for reviewing instances where things did not go according to plan, identifying the lessons that can be learned, and then ensuring that these lessons are embedded within the organisation. To support this, organisations need sufficient corporate memory of why previous decisions were or were not taken and the facts that informed those decisions.

78 Infrastructure and Projects Authority, 'Principles for project success', 2020, available at: www.gov.uk/government/publications/principles-for-project-success

> "Overall, a culture of curiosity within our organisations where we are keen to identify and learn from things that have gone wrong requires documenting those things and having open 'lessons learned' conversations. That will hopefully reduce the incidence of taking actions purely on the basis of reputation and the imperative to protect the organisation over a particular public interest."
>
> **John Edwards, Information Commissioner, Joint Association of Chief Executives and Public Chairs' Forum event, 3 July 2024**

6. A topic of conversation at a roundtable with public body chairs and chief executives hosted by the Association of Chief Executives and the Public Chairs' Forum was how public bodies should take note of recurring themes when things go wrong elsewhere in public life and consider what their own organisation might learn from them. For example, a constant theme in maternity services failures is the poor relationships between nurses, midwives and doctors. Poor relationships should therefore be viewed as a warning sign that the conditions are present for problems to develop in the delivery of public services. Learning from this insight, leaders may wish to reflect on, and invest in, the health of the working relationships within their own teams. Another example is the Post Office Horizon IT inquiry, which is considering the failings of the Horizon IT system which led to sub-postmasters being wrongly prosecuted for theft, fraud and false accounting. Leaders of organisations that use 'black-box' systems should be asking themselves whether they are confident that they have sufficient understanding and oversight of how these systems operate or whether they need greater assurance about their use.

> "It is crucial that public bodies do not overlook learning from previous experience and good practice, both inside and outside of the organisation, as this can also lead to failings. This includes implementing recommendations from external reviews of organisations. For example, the Francis Report, the RHI inquiry report, and the independent review of Invest NI. Good practice specifically on raising concerns is set out in 'Raising Concerns: A Good Practice Guide for the Northern Ireland Public Sector.'"
>
> **Northern Ireland Public Sector Chairs' Forum, open consultation, submission 19**

7. We asked Chief Constable Gavin Stephens, Chair of the National Police Chiefs' Council (NPCC), how the NPCC ensures that learning from independent inquiries into the police is shared across all the police forces in the UK. The NPCC has a series of co-ordinating committees on topics such as crime, local policing, workforce and finance, each chaired by a chief constable. Within these co-ordinating committees, there are a series of portfolios and working groups. When an independent inquiry reports, the chief constables of all the police forces come together through the Chiefs' Council to consider the recommendations and the individual portfolios are tasked as appropriate.

> "If we take a current [inquiry] the Angiolini Inquiry Part 1 report has a series of recommendations in there. I will chair a gold group looking at the series of recommendations. Naturally, they will fall into individual portfolios within that committee structure. They will do the work. We will come together in a national co-ordinating mechanism and take lessons or any key decisions through what we call the Chief Constables' Council. Effectively, that is all the chiefs coming together to address those issues. Alongside that, we have a series of other mechanisms, such as all chief officer education days, feedback into Andy [Chief Constable Andy Marsh] at the college's [College of Policing] service provision, executive leadership courses and middle management leadership courses."
>
> **Chief Constable Gavin Stephens, Chair, National Police Chiefs' Council, 10 May 2024**

8. Some contributors mentioned how fear of blame can inhibit learning when things go wrong. An example of an approach to investigations that addresses this potential obstacle to putting learning first is the Health Services Safety Investigations Body, set up in October 2023 to investigate patient safety concerns across the NHS in England and in independent healthcare settings. The body's core role is to carry out independent patient safety investigations that do not attribute blame or liability to individuals or organisations. Taking as a model the approach of other 'safety-critical' industries such as aerospace, aviation, maritime, rail, oil and gas, defence and nuclear power, the Health Services Safety Investigations Body investigates with a focus on system factors, rather than human error, with the aim of reducing the likelihood of patient safety incidents from happening.[79]

Improvement and evaluation

9. We were told about various mechanisms for improvement and evaluation in the public sector. Cat Little told us how evaluation in government has been improving over the last few years, in particular through the Evaluation Task Force and the What Works Network. The Evaluation Task Force is a joint Cabinet Office-HM Treasury unit that provides departments with evaluation advice and support (in response to department requests), as well as a 'proactive' scrutiny and challenge function.[80] The What Works Network, which is a network of research centres covering a range of policy areas from education to crime to health, aims to improve the way government and other public sector organisations create, share and use high-quality evidence in decision-making.

79 Health Services Safety Investigations Body, 'Annual Report and Accounts 2023/24', 22 July 2024, available at: **https://hssib-ovd42x6f-media.s3.amazonaws.com/production-assets/documents/hssib-annual-report-and-accounts-2023-24-accessible.pdf**

80 Evaluation Task Force, 'The Evaluation Task Force Strategy 2022 – 2025', 22 March 2024, available at: **www.gov.uk/government/publications/the-evaluation-task-force-strategy-2022-2025**

> "I think if you do not evaluate and humbly get people to properly evaluate things, how else do you learn lessons? I would like to see much more evaluation and evaluation strategies at the start of policy development."
>
> **Cat Little, Permanent Secretary, Cabinet Office, 24 July 2024**

10. The College of Policing holds the evidence base for policing. Chief Constable Sir Andy Marsh told us that as well as hosting the What Works Centre for Crime Reduction, the College of Policing has a practice bank for innovative and promising practice which is not yet fully evaluated. The college has produced a piece of research called Perennial Problems in Policing that clusters recommendations from His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS), Coroner's Court and the Independent Office for Police Conduct into 10 perennial problems to guide their research, training and investment. These include the prioritisation of short-term reactive policing, a lack of structured problem solving by frontline officers, limited assessment of the impact of specific interventions and strategies, and challenges in sharing information across partners.[81] The What Works Board, chaired by Chief Constable Marsh and attended by the NPCC, HMICFRS, APCC and other senior leaders prioritises the areas of learning, knowledge and innovation for testing.

> "We are turning more and more of these gaps into knowledge, and we are turning more and more of this knowledge into insight, which we share."
>
> **Chief Constable Sir Andy Marsh, Chief Executive, College of Policing, 31 May 2024**

11. Chief Constable Sir Andy Marsh and Chief Constable Gavin Stephens share the view that there is under-investment in central capacity to help police forces to improve. There is a focus within the policing system on understanding why things have gone wrong, but insufficient investment in central capacity to help organisations with routine learning and improvement. Policing is a localised system, but at the local level, police forces are often wrestling with many conflicting priorities including balancing the budget, implementing the latest IT system or doing the latest training programme to ensure legal compliance.

> "In a policing landscape or system that is heavily localised, I feel like we underinvest in the central capability. For example, policing is a £18 billion service or industry. The College of Policing – you have learned a little bit about our role, which I would characterise, by the way, as standards, performance, leadership – is a £70 million organisation."
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> **Chief Constable Sir Andy Marsh, Chief Executive, College of Policing, 31 May 2024**

81 College of Policing, 'Problem-oriented policing', January 2021, available at: **https://assets.college.police.uk/s3fs-public/2021-05/problem-solving-scope-of-practice-guidelines-250521.pdf**

> "There is a real absence of change and improvement capability in policing. I will put that alongside there is not an absence or a shortage of diagnostics about the things that are going wrong so whether that is coming from the Independent Office for Police Conduct (IOPC) who produce very good and effective learning reports, or HMICFRS, who have also produced lots of recommendations. We have probably struggled since the years of austerity and the closure of what was called the National Policing Improvement Agency. We lost that during the years of austerity. So, what is missing in policing is that there is not any central capacity to help forces improve."
>
> **Chief Constable Gavin Stephens, Chair, National Police Chiefs' Council, 10 May 2024**

12. In the health sector there are various programmes and schemes that NHS England have in place to support hospital trusts and Integrated Care Boards (ICBs). NHS England has statutory accountability for oversight of ICBs, NHS Trusts and foundation trusts. The NHS oversight framework describes how this oversight operates.[82]

13. The support provided by NHS England to an ICB or trust is based on earned autonomy principles. The NHS will identify the scale and nature of support needs by making an assessment about the maturity of the leadership in place within an ICB or trust and its performance. This will vary from a high degree of autonomy at one end of the scale and at the other end, mandated intensive support delivered through the Recovery Support Programme.[83]

14. We were also told about the Getting it Right First Time programme (GIRFT) which is a NHS England programme designed to improve treatment and care by reviewing health services in England.[84] GIRFT assists organisations to understand where they might be out of line with national data in the delivery of services by asking why variation might be occurring and, where it is unwarranted, assisting local teams to do the work that is needed to improve. Often, the NHS does this by pointing to another organisation that has had similar issues and has successfully put in place measures to resolve them.

82 NHS England, 'NHS oversight framework', June 2022, available at: **www.england.nhs.uk/publication/nhs-oversight-framework-22-23/**; 'A consultation on a draft updated NHS Oversight and Assessment Framework', May 2024, available at: **www.england.nhs.uk/long-read/consultation-on-the-draft-updated-nhs-oversight-and-assessment-framework/**

83 NHS England, 'Recovery Support Programme', available at: **www.england.nhs.uk/system-and-organisational-oversight/national-recovery-support-programme/**

84 NHS England, 'About the GIRFT programme at NHS England', available at: **https://gettingitrightfirsttime.co.uk/what-we-do/**

"Let me give you a case, at the moment, I am visiting all 24 comprehensive stroke centres in the country. We go through the data with them, and that allows us to ask questions around, 'Why are fewer of your population having a certain procedure?' The GIRFT programme partly physically visits, and partly looks at the data and issues reports based on analysis of that data, but fundamentally it is there to assist."

Professor Stephen Powis, National Medical Director, NHS England, 24 July 2024

15. Peer challenge can be a valuable tool to support improvement in public services. In the local government sector, the LGA facilitates a programme of corporate peer challenges (CPCs) for councils.

Corporate peer challenges for councils

Openness to external challenge contributes to honesty and openness. The LGA facilitates a programme of corporate peer challenges (CPCs) for councils, where a team of member and officer peers from local authorities provide 'critical friend' challenge on the themes of: local priorities and outcomes; organisational and place leadership; governance and culture; financial planning and management; and capacity for improvement.

CPCs are recognised as an effective tool for identifying any cultural and relationship weaknesses in councils and recommending improvements that help to mitigate individual or systemic risks. The government has set out its expectation in the Best Value Standards that all local authorities have a corporate or finance peer challenge at least every five years, to help identify any issues an authority might be facing and suggest possible solutions.[85]

Following each CPC, a report outlining the key findings and recommendations from the peer team is shared with the council. In the spirit of openness and transparency, councils are required to publish this report, alongside an action plan, within three months of the CPC. If the council is unable to publish the plan with the report, it is required to publish the plan no later than five months after the CPC. In 2023/4, 61 CPCs were conducted: reports are also published on the LGA website.

Local Government Association, open consultation, submission 14

85 Ministry of Housing, Communities & Local Government, 'Best value standards and intervention: a statutory guide for best value authorities', 8 May 2024, available at: **www.gov.uk/government/publications/best-value-standards-and-intervention-a-statutory-guide-for-best-value-authorities**

Complaints

16. Complaints can provide valuable insight for an organisation into how the public is experiencing its services. A spike in the volume of complaints in a specific geographical area or about particular policies or practices can be an early warning sign that there are issues that warrant closer investigation. Problems may start to reveal themselves in the complaints data before they materialise elsewhere in the department.

17. Whether complaints are viewed as an opportunity or a threat is determined by the tone set by the leadership of an organisation. It requires leaders, at all levels, to value and prioritise the learning to be gained rather than resorting to blame, defensiveness and reputation management.

> "Creating a learning organisation and one that does not blame is absolutely essential. You need all kinds of ways of doing that. We brought into our office former complainants who described what it was like to be on the receiving end of the behaviour of our people. We [also] brought in ombudsman leaders from Canada, Africa and across the world to talk about their experience and what they had done."
>
> **Sir Rob Behrens, Former Parliamentary and Health Service Ombudsman, 26 April 2024**

18. The role of the complaints caseworker is of critical importance to an organisation, in resolving issues that the members of the public are experiencing with public services and in identifying early warning signs of emerging problems. It is another role, like that of managing the sponsorship relationship with ALBs, which is crucial to the effective operation of public services but is at risk of being undervalued.

Government departments, public bodies and the NHS

19. The Parliamentary and Health Service Ombudsman (PHSO) was set up by Parliament to consider complaints that government departments, other public bodies and the NHS in England, have not acted properly or fairly or have provided a poor service. The PHSO also works with organisations to help them improve how they handle complaints and in 2022 published the UK Central Government Complaint Standards and the NHS Complaint Standards. The complaint standards have professionalised complaints handling by promoting a consistent cross-government approach to complaint handling.

20. The complaints standards encourage a learning culture by supporting organisations to see complaints as opportunities to improve services. The standards were developed in collaboration with departments and supported by the Cross Government Complaints Forum, which has the aim of improving the quality of complaint handling across government by enabling cross-departmental engagement and learning.

21. We were keen to hear the perspective of complaint handlers and were grateful to be invited to a meeting of the working level branch of the forum. It was clear to us that the forum is hugely valued by its members as a mechanism for bringing together people from a wide range of departments with contrasting complaints functions. Some departments may have a single person who handles complaints and may receive around 100 complaints a year. The larger departments will have large customer services departments and may receive around 90,000 complaints a year. The forum allows complaints handlers from all types of departments to come together to share best practice and experiences.

22. We were interested to hear how departments identify themes in the complaints they receive and how they use this to identify and resolve issues. We heard that departments that have the largest number of complaints as a consequence of the high volume of their customer service interactions, have a data analysis capability that is able to identify and report on trends and themes. In some smaller departments, the analysis is carried out by the team investigating the complaints.

23. There is also variation in the technical systems for recording and analysing the complaints data. For example, one larger department has a new handling system which pulls themes and outcomes into a performance report which is sent monthly to their board. We heard that the technology is lacking in some of the smaller departments. In some departments the case management system does not allow more than one reason for a complaint to be recorded or for detailed analysis of the data to be extracted. Some departments were in the process of building better systems, while others had not been supported by the resources necessary to invest in more appropriate systems for capturing the level of data necessary. For departments without sophisticated case management systems, complaints teams were relying on manual sifts to identify the granularity needed to pull out useful data.

24. One participant from an ALB shared with us an example of how they use their complaints data to identify red flags. The agency overlays data on the volumes of complaints about specific themes with the peaks that they would expect to see based on seasonal factors that impact on the work of their organisation. This method reveals increases that it is able to discount because they are in line with expectations. The agency is looking for peaks that are not attributable to seasonal variations, which might therefore suggest an anomaly which requires closer investigation.

25. We heard that there are some initial conversations taking place around whether AI can and should be used to support analysis of themes in complaints. One complaints handler noted that early dialogue within their public sector body seemed to be focused on the scope for AI to make efficiencies through potentially generating acknowledgments and complaint responses and not, rather worryingly, on how it can be used to facilitate learning and improvement.

26. We heard several examples where there was a clear route for themes identified in the complaints received to be escalated through the organisation to the executive leadership team and to the departmental board, including how the data is fed into the organisation's risk and assurance committee. Timeliness is important if the red flags are to be spotted and addressed before issues become more serious.

27. One participant at the forum shared how complaints handlers are able to see the changes that happen as a result of the feedback they are recording and the work of the data analysts to bring the reports together. This approach reinforces the message that identifying problems at the first opportunity and making improvements is a priority for the organisation. In contrast, another contributor spoke about how they thought that the staff handling complaints within their department would feel encouraged to collect the best data if they knew that change would happen once they collect the data. They felt that if the senior civil servants within their department were more visible, listening and taking on board the opinions of staff, this would encourage feedback to come from the frontline staff up the chain. We also heard that in some cases boards can be more interested in reducing backlogs and meeting key performance indicators than in asking what learning the organisation can take from the complaints.

28. One complaints handler from an ALB that operates nationally with regional offices told us how variations in the complaints that were being received for the regions led them to establish that the body was applying different processes in different regions. They were able to use complaints data to help them to determine what the policy should be nationally, and to publicise it to the public. This led to an increase in complaints in the short term, but in the long term it led to an overall decrease in complaints.

> "Complaints are not necessarily a bad thing. They are a way of ably informing you about how we can focus our efforts, and that has caused an overall benefit to our customers and the business in general."
>
> **Participant, Cross Government Complaints Forum, 24 October 2024**

29. One participant from an ALB explained how common themes in the complaints received revealed that customers were unhappy with the service the agency was providing. Customers were having difficulty getting through on the helplines, the waiting times were too long and when they did get through, the staff in the customer service centres were not trained well enough to be able to answer their queries. They were offered callbacks that then never happened. As a result of the complaints received, there was recognition that change was needed and this led to a huge culture shift in the agency.

> "There has been a really big push on, 'Let us pick up the phone. Let us talk to our customers. Let us get to know our customers again.' We have gone full circle back to the good old days when we used to speak to customers. It is a work in progress. We are not there yet, but I think that has been a really big change that we have seen just through complaint handling. That has been some of the things that we have put in play because of what we saw coming through complaints."
>
> **Participant, Cross Government Complaints Forum, 24 October 2024**

Local government

30. The Local Government and Social Care Ombudsman (LGSCO) conducts independent investigations into complaints about local councils (excluding town and parish councils) and some other authorities and organisations. The LGSCO also investigates complaints about adult social care providers in both the public and private sectors.

31. The LGSCO published the Complaint Handling Code in 2024, which sets out guidance on how local councils should handle complaints. Like the complaints standards issued by the PHSO, the Complaint Handling Code promotes a learning culture.[86] It advises organisations to look beyond the circumstances of the individual complaint and consider whether service improvements can be made as a result of any learning from the complaint.

32. The LGSCO shared with us an example of a council which has demonstrated that it is moving to a learning culture. Liverpool City Council had been through serious problems and was subject to a government intervention. It approached the LGSCO to ask for guidance on how to handle complaints effectively and on how to use the information gained from complaints to improve their services. Investigators from the ombudsman spent some time at the council and produced a report, which the council then implemented.[87]

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86 Local Government & Social Care Ombudsman, 'Complaint Handling Code', February 2024, available at: **www.lgo.org.uk/information-centre/information-for-organisations-we-investigate/complaint-handling-code**

87 Local Government & Social Care Ombudsman, 'Ombudsman encouraged by Liverpool's response to complaints review', 27 July 2023, available at: **www.lgo.org.uk/information-centre/news/2023/jul/ombudsman-encouraged-by-liverpool-s-response-to-complaints-review**

"Liverpool City Council have seen an absolute shift in internal culture, whereby they have started listening to people in a different way. It has not been that immediate defensive, 'No, it is not us.' People get caught up in that, where there is no direction within the organisation. Somebody then makes a complaint about something they have done, and it is the last thing they want to hear. If you shift the attitude to say, 'Okay, if we listen to what this person is saying, give them the space and time to express their views, it is likely that is going to help us understand how what we are doing is landing with the people who are relying on our service.' Liverpool is a very good example of an open mind and a bold approach."

Nigel Ellis, Chief Executive, Local Government and Social Care Ombudsman, 10 May 2024

33. The LGSCO shares learning that it has identified through the complaints it investigates in thematic reports, which conclude with a list of questions for councillors to ask when scrutinising services in their authority.[88]

34. Councillor Marianne Overton, Vice Chair of the LGA, shared the LGA view that it is good practice for an annual report on complaints to go to the full council. Councillor Overton also drew attention to a web service called Fix My Street run by the charity mySociety, which allows people to report problems in their local area, such as potholes or graffiti, using a shared 'front door'. The service sends the report to the right council which sends instructions directly to their contractors to fix the problem before a formal complaint is necessary. We heard from many contributors to our review that people do not tend to want to make complaints – they just want their problem to be fixed.

"It is again about culture, because you have to be prepared to see every complaint, not as something to defend against, but as a lesson. It is so vital."

Councillor Marianne Overton, Vice Chair of the Local Government Association, 14 June 2024

88 Local Government & Social Care Ombudsman, 'Focus Reports and Good Practice Guides', available at: www.lgo.org.uk/information-centre/reports/focus-reports

Chapter 7: Leadership and culture

The role of leaders in setting the tone

> "If you have the 'right' people, people with the right skills, the right attitudes, the right behaviours, the right experience and confidence to do the right thing, that is a large part of the battle on this. The best governance systems in the world and the best data in the world cannot protect an organisation or the public interest against the wrong individuals. People and behaviour are, in my experience, always the biggest single factor, but they are then part of a whole system."
>
> **Gareth Davies, Comptroller and Auditor General, National Audit Office, 24 May 2024**

1. It is clear to us that leadership is the most important factor in an organisation that identifies and addresses emerging issues promptly and is willing to learn from its mistakes. Leaders, at all levels, must create an expectation that employees will speak up if they notice something that 'doesn't quite feel right' and that doing so will be welcomed and valued. This goes deeper than warm words shared in a 'town-hall' meeting or an all-staff email. It is about how leaders demonstrate day in and day out through their actions and behaviours that they believe problems should be identified and confronted head-on.

2. In our 2023 report, Leading in Practice, we said that leaders must communicate the high standards they expect from their workforce with **clarity** and **consistency**, and that there must be **consequences** for people whose behaviour does not align with the values of the organisation. We discuss below what these themes mean for building a culture that supports identifying and addressing problems.

3. **Clarity.** Leaders must be clear that they welcome potential problems being brought to their attention early, before matters start to deteriorate, and they must emphasise that they expect all line managers to be receptive to issues and concerns being raised with them. Leaders must look for opportunities to help the people working in their organisation to understand how serving the public interest should guide their actions and behaviour. They must be clear that everyone in the organisation has a duty to deal with the public with openness and honesty.

4. **Consistency.** Leaders must be role models for the standards they expect of others, even when they are under pressure. They should demonstrate that they welcome people sharing their concerns or opinions by listening attentively. The organisation's internal culture should align with its public interactions. Ensuring consistency between its internal and external behaviours fosters honesty and transparency.

5. **Consequences.** Leaders must address behaviour that is inconsistent with a culture which values people raising concerns. The appropriate response will depend on the circumstances. Where malpractice has occurred, such as deliberately concealing relevant information, disciplinary action may be appropriate. In other instances, it may be right for the leader to call out a particular type of behaviour and explain why it is not acceptable.

Leaders must be careful not to reward people who downplay problems or sweep them under the carpet through favourable performance management decisions. In public life, the 'how' is as important as the 'what' in getting things done.

6. In the report of the Infected Blood Inquiry, Sir Brian Langstaff drew attention to the high number of high-profile failures of care over the last five decades that have been the subject of inquiries of different types which have ended with a recommendation that the culture needed to change to be more open and forthcoming.[89] He noted how these concerns have led to a statutory duty of candour being placed on health service bodies in England, Scotland and Wales, warnings from the Parliamentary and Health Service Ombudsman and a strengthening of whistleblower protection. However, he noted that there had not yet been the desired culture change.

> "Whistleblowers are recognised as capable of providing a valuable service. The protection given to them consists of ensuring they do not suffer a detriment for making the revelations which they do. However, the system is one in which it is almost assumed that, but for the Act [Public Interest Disclosure Act 1998], a whistleblower would otherwise be subject to blame. It is that cultural assumption which most needs to be addressed. What most needs to be valued is ensuring that reporting near misses ('sentinel events') as well as harmful acts is prized, so that we may learn how to avoid them next time a similar situation occurs."
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> **Infected Blood Inquiry, The Inquiry Report, Vol. 1, page 238**

7. One of these inquiries was Sir Robert Francis' 2013 report into Mid Staffordshire NHS Foundation Trust, in which he recommended that, "Reporting of incidents of concern relevant to patient safety, compliance with fundamental standards or some higher requirement of the employer needs to be not only encouraged but insisted upon."[90] Sir Brian Langstaff said that insisting on the reporting of concerns on the part of those in leadership roles was vital if culture is to change, along with the better organisation of the systems dealing with safety across healthcare. "Rather than seeing a whistleblower as needing protection from retribution which would otherwise follow, the culture should be one in which the reporting of the concerns of which Sir Robert Francis speaks is recognised as a human, professional and statutory duty." The duty should also rest on those to whom a report is made. Sir Brian recommended that those in leadership positions be required to record, consider and respond to any concern about the healthcare being provided and any person in authority to whom such a report is made should be personally accountable for a failure to consider it adequately.

89 Infected Blood Inquiry, 'The Inquiry Report', 20 May 2024, available at: **www.infectedbloodinquiry.org.uk/reports/inquiry-report**

90 'Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry', 6 February 2013, available at: **www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry**

> "Where an individual is responsible for something going wrong that was, or might have been, harmful, they should not usually be blamed for 'owning up' (for that enables patient safety to be better achieved), but they should certainly be blamed if they keep silent."
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> **Infected Blood Inquiry, The Inquiry Report, Vol. 1, Sir Brian Langstaff, page 241**

8. In his 2017 report, 'The patronising disposition of unaccountable power', Bishop James Jones proposed a charter intended to support leaders of public bodies to demonstrate to their employees that they are in favour of openness and against defensiveness. The Hillsborough Charter has since been adopted by the government, the National Police Chiefs' Council on behalf of all 43 police forces, the College of Policing, the Crown Prosecution Service, National Fire Chiefs' Council and others.[91]

> "The Hillsborough Charter works by looking to public authorities to adopt principles. It is about principles and the principles are about openness, candour and transparency. There needs to be that signal sent through the organisation, so that, when there are signs then staff feel, 'Yes, I want to bring this to the attention of others up the line', not, 'My job is to somehow pretend that this signal is a false signal or a minimal signal.' That can make all the difference."
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> **Ken Sutton, secretary to the Hillsborough Independent Panel and secretary to the reviews into maternity care at East Kent Hospitals NHS Trust, 11 July 2024**

9. There has been a statutory duty of candour for health and social care providers since November 2014 and an organisational duty of candour for policing was put in place though the 2023 Code of Practice for Ethical Policing.[92, 93] Campaigners have long called for a Hillsborough Law to set out in statute that all public authorities and public servants must tell the truth and act with candour. The government announced in the 2024 King's Speech that it would legislate to introduce a duty of candour for all public servants and the law would include criminal sanctions for those who breach it.[94]

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91 Oral statement to Parliament, 'Hillsborough Charter is legacy of victims' families', 6 December 2023, **available at: www.gov.uk/government/speeches/hillsborough-charter-is-legacy-of-victims-families**

92 A review of the operation of the statutory duty of candour for health and social care providers in England was announced in the government's response to the Hillsborough disaster report on 6 December 2023. A call for evidence was launched in April 2024 and the findings were published in November 2024, available at: **www.gov.uk/government/publications/findings-of-the-call-for-evidence-on-the-statutory-duty-of-candour**

93 College of Policing, 'Code of Practice for Ethical Policing', 7 December 2023, available at: **www.college.police.uk/ethics/code-of-practice**

94 BBC News, "Hillsborough Law' on the table by anniversary – PM', 24 September 2024, **available at: www.bbc.co.uk/news/articles/c0jwzgpzzjxo**

10. We welcome the government's commitment to increasing candour and openness in public life. The new legislation will need to be supported by sustained attention from leaders of public bodies to ensure that the law is both the catalyst for change and is supported by a culture that values and promotes openness over defensiveness.

11. We have seen in the reports of independent inquiries how, when the public has suffered as a result of action or inaction by a public sector body, it is often the defensive response of the body and its failure to acknowledge where it went wrong and offer a meaningful apology, that compounds the pain suffered. Point 5 of the Hillsborough Charter calls on organisations which sign it to strive to, "Ensure all members of staff treat members of the public and each other with mutual respect and with courtesy. Where we fall short, we should apologise straightforwardly and genuinely."

12. Some contributors to our review noted the difference between a legalistic approach and an approach centred on ethics and values. For example, a CEO may feel pressure from legal advisers to protect against potential legal liability and will need to balance this with the delivery of timely and effective public services in line with the organisation's values. Leaders need to decide what kind of culture they want for their organisation.

> "If you make a mistake, and we all do, I make them all the time, be able to say, 'Yes, I got that wrong.' That goes such a long way. It is not trying to live by some kind of virtuous code that other people cannot aspire to. It is trying to do the basic things which are about humanity and humility."
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> **Anthony May, Chief Executive, Nottingham University Hospitals NHS Trust, 24 May 2024**

Building a speak up culture

Speaking up and whistleblowing

'Speaking up' can include 'whistleblowing'. Whistleblowing of certain categories of wrongdoing is protected in law. Where a concern falls within the scope of the Public Interest Disclosure Act 1998 (PIDA), a worker making a 'protected disclosure' will be protected from negative treatment or unfair dismissal.

When we refer to speaking up in this report, we have in mind formal speak up and whistleblowing complaints, supported by effective policies and procedures for people to raise concerns. But we also have in mind a culture where people feel comfortable flagging issues informally, asking questions and sharing their ideas. This can enhance the engagement and collaboration that makes for good decision-making in the public interest.

13. An organisation that approaches public scrutiny openly and transparently, does not seek to defend the indefensible and treats the public with respect, needs an open internal culture that supports employees to speak up if they become aware of actions or behaviours that are falling short of these standards.

14. The annual 'Ethics at Work' research published by the Institute of Business Ethics consistently finds that the main barriers to speaking up are fear and futility. People fear that speaking up will have a negative impact on their career and lack confidence that any action will be taken if they do raise their concerns. Other reasons that may apply include a fear of blame or not wanting to be seen to undermine colleagues.[95]

15. To inform their contribution to our public consultation, the Society of Local Council Clerks conducted a survey of their membership. The survey asked whether members feel safe to speak up about concerns with 62% responding 'yes' and 38% responding 'no'. The survey asked those who had responded no, what they believed were the reasons for this response. 37% said their negative response was due to a lack of proper sanctions for poor behaviour which in turn can mean that councillors and staff feel it is not worth raising an issue.[96]

16. Some contributors raised with us the importance of psychological safety for creating a culture where people are willing to speak up. Academic and author, Dr Amy Edmondson, defined team psychological safety in 1999 as, "a belief that one will not be punished or humiliated for speaking up with ideas, questions, concerns, or mistakes, and that the team is safe for interpersonal risk taking."[97]

17. In our 2023 report, Leading in Practice, we explored the role of leaders in creating an environment where people feel they can speak up. Three observations from that report are worth summarising here:

    - People need to feel that leaders are genuinely interested in what they have to say, and leaders need to be visible and available.
    - The way leaders respond when people raise concerns has a ripple effect though an organisation – for good or bad.
    - Strong leadership requires leaders to be curious about their organisation and to welcome concerns and complaints as information that will enable them to make improvements.

18. These themes continued to be prominent in the evidence we took for this report. When leaders take action, this demonstrates that leaders take seriously the matters being raised with them. Baroness Casey described the chicken and egg nature of the problem, "If you do not take action, people will not come forward. If people do not come forward, you will not be able to take action."

95 Institute of Business Ethics, open consultation, submission 11

96 Society of Local Council Clerks, open consultation, submission 23

97 Amy C. Edmondson, 'Psychological Safety', available at: **https://amycedmondson.com/psychological-safety/**

> "If your first action on receiving a whistleblowing complaint internally, or negative feedback from somebody outside the organisation, is to get into reputational protection mode then, however good your policy, you have lost that point. It is again leadership, culture, behaviour and so on."
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> **Gareth Davies, Comptroller and Auditor General, National Audit Office, 24 July 2024**

> "In our confidential staff surveys, since 2016, you can see that there is appreciation for the leaders getting out, talking to their colleagues and staff, listening to them, taking onboard what they say and welcoming when they have done something wrong, to be told that they have done something wrong. The leaders have to practise what they preach. If they do not, people become cynical and fearful."
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> **Sir Rob Behrens, Former Parliamentary and Health Service Ombudsman, 26 April 2024**

> "A key part of building a speak up culture is for managers to be trained in active listening, for all contributions, challenges and ideas to be valued, and to maintain the virtuous triangle through following up when issues are raised, to let colleagues know what has happened to their feedback – speak up, listen up, feed back."
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> **Institute of Business Ethics, open consultation, submission 11 Speak up and whistleblowing processes**

19. We have discussed in this chapter the importance of an open culture in which people feel it is their duty to speak up about concerns and near misses. It could be said that there has already been a failure of an organisation's culture if an employee feels that they need to report a concern formally. However, it is also the case that formal mechanisms are a crucial safety net and there will always be a need to have effective and trusted processes in place.[98]

20. Five key components of an effective speak up/whistleblowing system came through in the evidence we took.

    - It is important that there are a range of routes for people to speak up and that these are publicised within the organisation. There should be regular training and awareness programmes on the process, which are available to staff and board members.

98 There has been much debate in recent years about whether existing whistleblowing law is sufficient. Proposals have been made for improvements to the regime. For example, see: **https://protect-advice.org.uk/campaign-for-a-new-whistleblowing-bill/**

"It is important that there are regular training and awareness programmes on the whistleblowing process, which are available to staff and board members as appropriate."

Northern Ireland Public Sector Chairs' Forum, open consultation, submission 19

- Organisations have a duty of care to people who speak up and need to support employees through what can be a difficult and emotionally challenging time.

"We want to get the information from the whistleblower as quickly as possible, to reassure them that it has been understood and is being dealt with properly, which is often a challenge, but let them get back to their job. We have seen really serious effects on whistleblowers' mental health and their performance in the job. While everybody was well intentioned about protecting them, it has almost become impossible because they are under such stress. There is a duty of care point there, which is still not well managed."

Gareth Davies, Comptroller and Auditor General, National Audit Office, 24 May 2024

- All too often people who raise concerns face aggression and denial. Organisations should ensure that victimisation is dealt with firmly and that this is seen to happen.

"We are aware of employers in the public and private sector who successfully use a victimisation risk assessment to prepare and address the risk of victimisation of a whistleblower at a very early stage. A risk assessment can also identify risks to breaches to a whistleblower's confidentiality as well as situation."

Protect, open consultation, submission 21

- Boards should regularly review the operation of the speak up system and make improvements where necessary. So that the board can understand the experiences of people who report concerns, organisations need to collect data on the operation of the speak up system.

"Ensuring the effectiveness and awareness of a whistleblowing policy that empowers employees to disclose any serious wrongdoing or unlawful conduct without fear of victimisation is vital. Regular review of the policy and supporting training and communication is essential."

Local Government Association, open consultation, submission 14

- Boards should ensure that speak up reports are analysed for themes and patterns and that this information is combined with other datasets to form a single insight into the culture of the organisation.

> "I think it is partly about training. I think it is about rewarding whistleblowers. I do not mean necessarily financially. I think it is about building it into the culture of the organisation. In particular, I think the boards of both public and commercial bodies need to be specifically trained on why whistleblowing can be a positive, its importance and the risks and costs of ignoring whistleblowers."
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> **John Bowers, Principal of Brasenose College, University of Oxford, 25 June 2024**

21. Protect, the whistleblowing charity, has developed a whistleblowing benchmark, which has codified best practice into an evaluation tool to support employers to analyse their performance in three areas: governance (policies and procedures, accountability, review, and reporting arrangements), staff engagement (communications and training) and operations (support and protection, recording and investigations, resolution, and feedback). On completion, an organisation receives a score under each area, allowing comparisons with other organisations and against best practice, and providing a gap-analysis so that organisations know where to improve.[99]

Developing leaders

22. It is clear that leaders – at all levels of an organisation – are critical to a culture where people both feel that it is their duty to report mistakes and concerns and that they will not be unfairly treated for doing so. So how can public sector organisations ensure they are populated by leaders who have the motivation, character and skills necessary to build these cultures?

23. Dr Bill Kirkup shared his view with us, based on his experience of the health sector, that leaders often do not feel confident that they have solutions to problems so would rather not hear about them. He felt that if people were better prepared for the fact that things will go wrong and have thought about how they would deal with the challenges that could arise, they may be less inclined to minimise problems.

> "Very often, when you first go to do an investigation in somewhere like Morecambe Bay, the first thing that everybody tells you is, 'Everybody knew that there was a problem.' 'Yes, but why did you not say so?' 'Because we thought that people were not ready to listen.' If you are prepared to listen to those and you show that a report of potential problems is going to be welcomed and not rejected, that will add a lot to it. If people, again, thought that they had solutions to some of these problems, they would not be so frightened of them and they would not want to minimise them quite so much."
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> **Dr Bill Kirkup, Chair of reviews into maternity care at East Kent Hospitals NHS Trust and Morecambe Bay maternity services, 11 July 2024**

99 Protect, open consultation, submission 21

24. Developing the confidence of leaders to deal with problems in the right way seems to us to be a worthwhile area of focus in leadership training. This should include how to handle a crisis appropriately and how to get comfortable delivering bad news to their leaders and ministers – and doing it early.

25. We heard from contributors how leaders need to be curious in order to uncover and address issues as early as possible. Leaders must take action when issues are raised with them, but this alone is insufficient. Leaders must actively search out the first signs of issues that may be bubbling under the surface. We discussed in chapter 3 how hard and soft data across a range of areas can provide indicators that something may be going wrong and requires a closer look. But for this data to be used to best effect, leaders must want to listen to and interpret the story it is telling.

> "I am constantly looking for corroborating evidence or dissonance with the formal paperwork I see through governance. When there is dissonance, then you start pulling at the thread. Is the whistleblowing process not being used? Why are those the complaint numbers that we get? I see one of my roles, as part of the senior team, as making sure there is enough grit in the machine which ensures the infrastructure that I set up is asking some of the challenging questions, to make sure that things are what they appear to be."
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> **Angela MacDonald, Deputy Chief Executive and Second Permanent Secretary, HMRC, 11 July 2024**

26. This is not the place for an in-depth summary of the different forms of leadership training and development that are available in the public sector. However, the following schemes and methods are examples that were shared with us of training that supports leaders to develop organisational cultures where issues are addressed when they arise and the public interest comes first.

- The Infrastructure Project Authority (IPA) Project Hub and Major Project Leadership Academy (MPLA) train people to be accountable. All Senior Responsible Officers must go through the MPLA course, which is 18 months duration and is equivalent to a master's degree. The MPLA course includes a mix of training and experience-based work. The IPA has also given training to ministers.
- Immersive learning uses realistic environments to simulate major incidents and real-world scenarios. This allows participants to practise making decisions in a safe learning environment. Immersive learning is used by the police and in health, among other sectors.[100, 101]

100 College of Policing, 'Immersive learning', available at: **www.college.police.uk/career-learning/immersive-learning**

101 NHS England, 'Simulation and immersive technologies', available at: **www.hee.nhs.uk/our-work/technology-enhanced-learning/simulation-immersive-technologies**

- UK Government Investments (UKGI) has a shareholder non-executive director development programme and an aspiring shareholder non-executive director development programme to build a pipeline of expertise. They hold formal training sessions three or four times a year. Every time the UKGI produces an internal good practice note, they hold a seminar on it to disseminate expertise across the organisation. They currently have a programme where every six to eight weeks they bring in a FTSE 100 Chair to talk to the group about how effective boards operate. Charles Donald, Chief Executive of UKGI told us, "It is all about trying to build a group of people who a) do not feel like they are on their own and b) feel like they are being trained and developed to understand a good way to operate on a board. Those people also encounter problems that may exist in one ALB and a shared understanding of which means colleagues might be in a better position to recognise them elsewhere in another ALB. It is amazing how many themes that are common."
- Cross-sector learning allows for cross-fertilisation of ideas across the public sector. An example is the Ethos Network, attended by senior representatives from the Police, Military, NHS, Civil Service and academics researching ethics in diverse public services. Subject to securing funding, the Ethos Network will develop a cross-sector research agenda and evidence base for ethics in (and of) public service, facilitate mutual learning on, and advancement of, ethics in (and of) public service, through interprofessional and multidisciplinary networking and engagement, and identify and share best practice on education, standards, and services for ethics in public service.
- The LGA's member and officer development programmes promote the importance of fostering open and transparent communication and engagement in local authorities between Cabinet/committee chairs and senior officers and with the public and stakeholders to facilitate information exchange and feedback in an open, honest and accountable way.[102]

27. In our Leading in Practice report, we were clear that while the tone at the top of the senior leadership is important for setting culture, most people working in organisations will have limited visibility of the top team but daily interactions with their more immediate managers. Line managers at all levels need training and support so that they are able to create the right atmosphere for their staff to feel safe saying they have made a mistake, or that they feel a project may not be going to plan, and line managers need to know how to handle such challenging conversations.

28. Another area we touched on in Leading in Practice was the role of professional standards in supporting members of the professions to maintain high standards and act as role models within the public sector organisations where they work.

102 Local Government Association, open consultation, submission 14

> "As part of the professional training [for accountants], there is an ethics module, and professional staff must review and remind themselves of their ethical responsibilities under the Standard of Professional Practice on Ethics. Things like honesty and courage are part of that, being able to speak truth to power and to do the right thing where required. It is absolutely acknowledged that that can be hugely difficult, and sticking your head above the parapet when circumstances are hard is a personally very challenging thing to do."
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> **Diana Melville, Governance Advisor, The Chartered Institute of Public Finance and Accountancy (CIPFA), 24 May 2024**

29. Cat Little told us that she would like to see greater professionalisation of what it means to be a civil servant and uphold the Civil Service Code.

> "We have got good frameworks, but I think we need to go further. The Civil Service Code, for example, has our four core values. We talk about honesty and impartiality, but we do not really have a professionalisation of what that means in practice. I compare that to my experience as a chartered accountant, where every year I had to explain how I had upheld my professional duties. I think the same is required of the Civil Service as professionals in policy making and with the responsibilities that we have."
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> **Cat Little, Permanent Secretary, Cabinet Office, 24 July 2024**

Removing disincentives to identifying issues and learning from them

30. We heard a view that some chief executives, when things go wrong, view their role as managing the organisation through a period of turbulence, rather than being curious about the cause. And when it comes to complaints, these can be seen as unwelcome rather than a source of helpful intelligence about the operation of the organisation. Part of the reason for this perspective may be down to how expectations and priorities are communicated. If it is made clear that leaders will be judged by the way they learn from complaints rather than how they manage them, this approach may have a positive impact on behaviour throughout the organisation.

31. One of the perceived barriers to the leaders of organisations escalating concerns to the organisation at the next level in the accountability chain is concern about that organisation's response. NHS England told us that it is a challenge to find a mechanism to protect and reward people for curiosity without layering on more processes. When concerns are raised in a trust, the regulatory process is engaged and a leader will need to go through a process of reviews and, potentially, special financial measures. As regulation can sometimes be a blunt tool for improvement when used in isolation, NHS England is focused on finding ways to ensure that the leadership and improvement support from the NHS available to trusts means that people feel it is worth raising concerns, asking for help and building a culture of learning.

32. We have discussed how addressing issues is the right thing to do in the public interest, but there is another consideration that leaders would do well to have in mind. With social media, it is becoming harder for organisations to avoid transparency. Organisations that construct a narrative to defend a situation are more likely to be exposed. This creates an opportunity to help people to recognise that it is better to be straightforward and upfront, rather than have to face the consequences for their reputation and career and if they are later revealed to have been responsible for a cover-up.

Recognising and responding to early warning signs

33. We have discussed in this chapter how public office-holders have a duty to speak up when they notice something going wrong and the importance of an organisational culture that values and facilitates open communication between colleagues. In many recent public sector failures, such as those mentioned in this report, there were warning signs that things were not as they should be. These warning signs were either not recognised or, for a variety of reasons, they were not acted on.

34. Public sector leaders have a responsibility to lead organisations that put the public first, and this means recognising mistakes, correcting course when things are going wrong and learning the wider lessons, even when this may be uncomfortable in the short term.

35. It is imperative that leaders make time to reflect on whether their organisation's processes and culture support recognising and responding to early warning signs. We have included in this report suggestions for how this might be achieved by sharing the experiences of people we spoke to from different parts of public life. But each organisation is different and constantly evolving, and what works for one organisation might not be the right approach for another.

36. Our 20 'points for reflection' are intended to help leaders to think deeply about the processes and culture in their organisation and consider whether there are improvements to be made. But the questions are not only for leaders. They are a resource to help public office holders at all levels to challenge their leaders to think about these important matters.

37. The 'points for reflection' must be read alongside the Principles of Public Life. As we explored in chapter 1, the Nolan Principles help to keep the decisions and behaviours of public office holders rooted in the public interest when priorities change and difficulties arise. Hindsight may show decisions to have been flawed – it is futile to expect perfection, but being guided by the Nolan Principles ensures that decisions are taken in the right way, for the right reasons. The public deserves no less.

Appendix 1: Common themes from recent inquiries

1. Failure to listen to and act on concerns raised by employees and/or the public

Windrush Lessons Learned Review

"Our evidence shows individual cases being brought to the attention of the Home Office, and people living in the UK legally feeling the force of Immigration Enforcement measures as far back as mid-2000s, well before the 2014 and 2016 hostile environment measures were in full effect."[103]

Ockenden Review

"It appears from our survey and interviews, albeit with limited staff numbers engaging, that many staff had raised concerns about safe staffing levels over a protracted period of time. Within the survey, 61% of respondents said that they escalated staffing concerns but just 33% of these received an adequate response."[104]

Infected Blood Inquiry

"One of the most striking aspects of the evidence has been a failure adequately to listen to patients and to hear what they wanted, rather than assume the "listener" already knew."[105]

"It is, in my view, of particular importance that where it is known (as is beyond doubt here) that there is a voice to be heard, but that it is currently speaking in a very quiet whisper, steps must be taken, as best can be done, to enable those who should listen to it to hear it far more loudly."[106]

Grenfell Tower Inquiry

"Some, perhaps many, occupants of Grenfell Tower regarded the TMO [Tenant Management Organisation] as an uncaring and bullying overlord, which belittled and marginalised them, regarded them as a nuisance or worse, and simply failed to take their concerns seriously."[107]

103 Windrush lessons learned review, page 44, 20 March 2020
104 Final report of the Ockenden review, page 187, 30 March 2022
105 Infected Blood Inquiry, Volume 1, page 272, 20 May 2024
106 Infected Blood Inquiry, Volume 1, page 274, 20 May 2024
107 Grenfell Tower Inquiry: Phase 2 report, Volume 3, page 37, 4 September 2024

2. Failure to investigate properly when things went wrong

Windrush Lessons Learned Review

"Ministers set the policy and the direction of travel and did not sufficiently question unintended consequences. Officials could and should have done more to examine, consider and explain the impacts of decisions."[108]

Ockenden Review

"... by early 2009 there was already a systematic failure within the Trust to investigate its maternity services. Following on from their failure to investigate the deaths of Joshua, Thomas and Kate, the Shrewsbury and Telford Hospital NHS Trust completely failed to identify appropriate actions for learning from the deaths of these babies."[109]

"Our consideration of clinical governance processes and documents at the Trust has shown that investigatory processes were not followed to a standard that would have been expected for the particular time the incident occurred. The reviews were often cursory, not multidisciplinary and did not identify the underlying systemic failings and some significant cases of concern were not investigated at all."[110]

Infected Blood Inquiry

"The NHS did not respond to the infection of thousands of people with HIV and hepatitis, through transfusion or treatment with blood products, by undertaking investigations, providing detailed explanations, making sincere apologies and doing everything that could be done to learn lessons. Instead, what is apparent is a defensive closing of ranks."[111]

Grenfell Tower Inquiry

"... we consider that more should have been done to investigate the propensity of composite panels to contribute to the downward spread of fire, the adequacy and clarity of the statutory guidance on the construction of external walls, including the suitability of Class 0 as a criterion and whether the use of materials liable to create flaming droplets when exposed to fire ought to be regulated."[112]

108 Windrush lessons learned review, page 7, 20 March 2020

109 Final report of the Ockenden review, page 17, 30 March 2022

110 Final report of the Ockenden review, Executive summary, page xi, 30 March 2022

111 Infected Blood Inquiry, Volume 1, page 190, 20 May 2024

112 Grenfell Tower Inquiry: Phase 2 report, Volume 1, page 143, 4 September 2024

3. Failure of the board to have proper oversight of issues and concerns

Windrush Lessons Learned Review

"In this review, the evidence shows that for the hostile environment measures ministers and officials did not fully consider risks and, after the measures were implemented, gave inadequate attention to understanding their effect, including whether discrimination had occurred. The review also found that mitigating action was insufficient and that ministers and officials neither considered nor requested a broader range of policy options. Arrangements for senior oversight were unclear and unstructured, as were the levels of approval for decisions."[113]

Ockenden Review

"The review has found the Trust leadership team up to Board level to be in a constant state of churn and change. Therefore, it failed to foster a positive environment to support and encourage service improvement at all levels. In addition, the Trust Board did not have oversight, or a full understanding of issues and concerns within the maternity service, resulting in a lack of strategic direction and effective change, nor the development of accountable implementation plans."[114]

Grenfell Tower Inquiry

"The board of the TMO [Tenant Management Organisation] was the body ultimately responsible for its affairs, including strategic decisions relating to matters affecting fire safety in the buildings it managed. It was therefore important that it be kept informed of developments as they occurred, but regrettably there were many instances in which important information was not drawn to its attention. RBKC [Royal Borough of Kensington and Chelsea] was responsible for the oversight of the TMO which reported to its scrutiny committees. Reports to the scrutiny committees did not always contain the information that might reasonably have been expected.[115]

113 Windrush lessons learned review, page 149, 20 March 2020

114 Final report of the Ockenden review, Executive summary, page x, 30 March 2022

115 Grenfell Tower Inquiry: Phase 2 report, Volume 3, page 14, 4 September 2024

4. Overly defensive organisational culture

Windrush Lessons Learned Review

"Given its [the Home Office's] sensitivity to public criticism, there is the sense that priorities and decisions have been driven by an overwhelming desire to defend positions of policy and strategy – often at the expense of protecting individuals from the impact of the policies."[116]

Ockenden Review

"The Trust consistently demonstrated negative behaviours and practices, resulting in many staff learning to accept poor standards as it became the cultural norm; this constitutes organisational abuse, similar to that found in the Mid Staffordshire NHS Foundation Trust Public Inquiry (2013)."[117]

Infected Blood Inquiry

"Standing back, and viewing the response of the NHS and of government, the answer to the question "was there a cover up?" is that there has been. Not in the sense of a handful of people plotting in an orchestrated conspiracy to mislead, but in a way that was more subtle, more pervasive and more chilling in its implications. To save face and to save expense, there has been a hiding of much of the truth. This failure to bring the true facts to life has come partly from the inertia of groupthink; but partly, it must be recognised from instinctive defensiveness, to save face and to save expense."[118]

Grenfell Tower Inquiry

"The Department [for Communities and Local Government] displayed a complacent and at times defensive attitude to matters affecting fire safety."[119]

"... for its part, the TMO ought to have reacted less defensively and, instead of retreating, should have made a greater effort to engage with Mr Daffarn, both on a personal and public level. It allowed its fear and personal mistrust of him and his methods to influence the way in which it engaged with the residents more generally. As custodian of the safety and security of its residents, it must take responsibility for the breakdown in trust."

116 Windrush lessons learned review, page 90, 20 March 2020

117 Final report of the Ockenden review, page 66, 30 March 2022

118 Infected Blood Inquiry, Volume 1, pages 190 to 191, 20 May 2024

119 Grenfell Tower Inquiry: Phase 2 report, Volume 1, page 10, 4 September 2024

5. Failure to support a ‘speak up’ culture

Ockenden Review

“Many staff members told the review team of the fear of speaking out within maternity services. This included those who are currently working in maternity services at the Trust.”[120]

“During the staff voices interviews some staff stated to the review team that there was a culture of bullying within the leadership team, and that this was not confined to the senior maternity management team but went across the Trust management structure.”[121]

Infected Blood Inquiry

“The fifth theme is that of institutional defensiveness, from the NHS and in particular from government, compounded by groupthink amongst civil servants and ministers, and a lack of transparency and candour. These factors drove the response of government over the decades.”[122]

Grenfell Tower Inquiry

“It is disappointing that when officials became aware of matters which posed serious risks to life, effective steps were not taken to draw those risks to the attention of ministers. The failure to foster a culture in which concerns could be raised and frank advice given represents a serious failure of leadership on the part of ministers and senior officials.”[123]

120 Final report of the Ockenden review, page 184, 30 March 2022

121 Final report of the Ockenden review, page 67, 30 March 2022

122 Infected Blood Inquiry, Volume 1, page 14, 20 May 2024

123 Grenfell Tower Inquiry: Phase 2 report, Volume 1, page 160, 4 September 2024

6. Poor relationships within the organisation

Ockenden Review

"... there was a culture of 'them and us' between the midwifery and obstetric staff, which engendered fear amongst midwives to escalate concerns to consultants. This demonstrates a lack of psychological safety in the workplace, and limited the ability of the service to make positive changes. Unfortunately, these poor working relationships were also witnessed by families, and in some cases mothers have described the additional stress these interactions had on them at one of the most vulnerable moments in their lives. In addition, repeatedly throughout this review we have heard from parents about a lack of compassion expressed by staff either while they were still receiving care or in follow-up appointments and during complaints processes."[124]

Grenfell Tower Inquiry

"… between 2011 and 2017 relations between the TMO and many of the residents of the tower were increasingly characterised by distrust, dislike, personal antagonism and anger … for the TMO to have allowed the relationship to deteriorate to such an extent reflects a serious failure on its part to observe its basic responsibilities."[125]

7. Failure to understand the unintended consequences of policy decisions

Windrush Lessons Learned Review

"Warning flags about the potential consequences of the policy were raised at various stages, in various ways and by various interested parties. Yet ministers and officials were impervious to these warnings because of their resolute conviction that the implementation of the relevant policies was effective, should be vigorously pursued and would achieve the policy intent."[126]

Grenfell Tower Inquiry

"In the years that followed the Lakanal House fire the government's deregulatory agenda, enthusiastically supported by some junior ministers and the Secretary of State, dominated the department's thinking to such an extent that even matters affecting the safety of life were ignored, delayed or disregarded."[127]

124 Final report of the Ockenden review, page 184, 30 March 2022
125 Grenfell Tower Inquiry, Volume 3, page 40, 4 September 2024
126 Windrush lessons learned review, page 137, 20 March 2020
127 Grenfell Tower Inquiry, Volume 1, page 11, 4 September 2024

8. Failure to learn from past mistakes, or similar incidents and failures

Windrush Lessons Learned Review

"A defensiveness borne of dealing with issues in the past, coupled with an inadequate comprehension of the potential scale and complexity of the problem, led to a lack of curiosity or willingness to learn or reflect."[128]

Ockenden Review

"In our interactions with families, we have seen clearly that the Shrewsbury and Telford Hospital NHS Trust failed to learn, failed to improve and failed to safeguard families over a prolonged period of time."[129]

"The review team … found evidence, over many years, of how a failure to investigate harm appropriately at the time meant learning opportunities were missed and subsequently led to other women suffering similar harm."[130]

Infected Blood Inquiry

"When it became apparent in the mid 1980s how many people had suffered serious illness as a result of their treatment with blood or blood products by the NHS, there was little apparent effort to establish precisely why that was, and to learn the lessons for the future."[131]

Grenfell Tower Inquiry

"Both the department and BRE [Building Research Establishment] were warned on a number of occasions about the problems that could be caused by the use of combustible materials in the external walls of tall buildings with specific reference to cladding fires that had occurred abroad. Those warnings appear to have generated at best some informal conversations between BRE and the department, but more could and should have been done."[132]

"Although we recognise that the Lakanal House fire had particular features that were not directly relevant to what occurred later at Grenfell Tower, there were lessons that could and should have been learnt from it which might have improved the robustness and clarity of the regulatory regime before the Grenfell refurbishment took place."[133]

128 Windrush lessons learned review, page 88, 20 March 2020
129 Final report of the Ockenden review, page 149, 30 March 2022
130 Final report of the Ockenden review, page 40, 30 March 2022
131 Infected Blood Inquiry, Volume 1, page 219, 20 May 2024
132 Grenfell Tower Inquiry, Volume 1, page 129, 4 September 2024
133 Grenfell Tower Inquiry, Volume 1, page 143, 4 September 2024

9. Failure to identify emerging themes that might have alerted the organisation to a developing risk

Windrush Lessons Learned Review

"When we were looking for information about specific issues, we found it impossible to access all the complaints, correspondence, press queries, Freedom of Information requests and Parliamentary questions which came into the department before Windrush became a departmental label. This information is held on disparate IT systems, and in no standardised format. The systems monitor response times and service standards rather than the emerging themes that might help the department more broadly as to the full extent of a risk once it's identified."[134]

Ockenden Review

"In summary, this was a Trust which had a number of problems, but the perception was that until 2017 the maternity service was not a major risk… The review team believes that the Trust Board and the CCGs [Clinical Commissioning Groups] were 'reassured' rather than 'assured' with regards to governance and safety within the maternity service. Although independent and external reports consistently indicated that the maternity service should improve its governance and investigatory procedures, this message was lost in a wider healthcare system which was struggling with other significant concerns."[135]

Infected Blood Inquiry

"It was not until May 1983 that there was within the DHSS [Department of Health and Social Security] any real focus on how best to respond to the risks of AIDS from blood or blood products and that was as a response to press reporting."[136]

Grenfell Tower Inquiry

"There was no analysis of the lessons to be learnt from significant single incidents, from the identification of patterns across different reporting periods, or from significant fires overseas. The work was being carried out at such a high level of generality that it would have been difficult for BRE [Building Research Establishment] to identify any patterns indicating that changes to the statutory guidance were necessary to ensure that it remained relevant to the risks posed by the built environment."[137]

134 Windrush lessons learned review, page 88, 20 March 2020

135 Final report of the Ockenden review, page 13, 30 March 2022

136 Infected Blood Inquiry, Volume 4, page 21, 20 May 2024

137 Grenfell Tower Inquiry, Volume 1, page 130, 4 September 2024

Appendix 2: About the Committee on Standards in Public Life

The Committee on Standards in Public Life (CSPL) advises the Prime Minister on ethical standards across the whole of public life in England. It monitors and reports on arrangements for upholding ethical standards of conduct across public life in England. The committee is an advisory non-departmental public body sponsored by the Cabinet Office. The chair and members are appointed by the Prime Minister.

CSPL was established in October 1994, by the then Prime Minister, with the following terms of reference:

> "To examine current concerns about standards of conduct of all holders of public office, including arrangements relating to financial and commercial activities, and make recommendations as to any changes in present arrangements which might be required to ensure the highest standards of propriety in public life."

The remit of CSPL excludes investigation of individual allegations of misconduct.
On 12 November 1997, the terms of reference were extended by the then Prime Minister:

> "To review issues in relation to the funding of political parties, and to make recommendations as to any changes in present arrangements."

The terms of reference were clarified following the Triennial Review of CSPL in 2013. The then Minister for the Cabinet Office confirmed that CSPL "should not inquire into matters relating to the devolved legislatures and governments except with the agreement of those bodies", and that "the government understands the committee's remit to examine 'standards of conduct of all holders of public office' as encompassing all those involved in the delivery of public services, not solely those appointed or elected to public office".

CSPL is a standing committee. It not only conducts inquiries into areas of concern about standards in public life but can also revisit those areas to monitor whether and how well its recommendations have been put into effect.

CSPL membership

Doug Chalmers CB DSO OBE, Chair

Professor Gillian Peele

Ewen Fergusson

The Rt Hon Lady Arden of Heswall DBE

John Henderson CB

The Rt Hon Baroness Beckett GBE

Baroness Finn

The Rt Hon Ian Blackford

Councillor Ruth Dombey OBE (from November 2024)

Chair of CSPL's Research Advisory Board

Professor Mark Philp

Secretariat

CSPL is assisted by a secretariat formed of Lesley Bainsfair (Secretary to the Committee), Nicola Richardson (Deputy Head of the Secretariat), Peter Keheller (Senior Policy Adviser), Amy Austin (Senior Policy Adviser) and Lesley Glanz (Executive Assistant). Press support is provided by Maggie O'Boyle.

Declarations of Interest

Members' declarations of interest can be found on CSPL's website and are updated regularly.[138]

Maggie O'Boyle also provides part-time press support to the Office of the Commissioner for Public Appointments, the Advisory Committee on Business Appointments, the House of Lords Appointments Commission, and the Civil Service Commission.

138 Committee on Standards in Public Life, available at: **www.gov.uk/government/organisations/the-committee-on-standards-in-public-life**

Appendix 3: The Seven Principles of Public Life

The Seven Principles of Public Life apply to anyone who works as a public office holder. This includes all those who are elected or appointed to public office, nationally and locally, and all people appointed to work in the Civil Service, local government, the police, courts and probation services, non-departmental public bodies (NDPBs), and in the health, education, social and care services. All public office holders are both servants of the public and stewards of public resources. The principles also apply to all those in other sectors delivering public services.

Selflessness

Holders of public office should act solely in terms of the public interest.

Integrity

Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.

Objectivity

Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.

Accountability

Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.

Openness

Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.

Honesty

Holders of public office should be truthful.

Leadership

Holders of public office should exhibit these principles in their own behaviour and treat others with respect. They should actively promote and robustly support the principles and challenge poor behaviour wherever it occurs.

Appendix 4: Stakeholders

Methodology

The committee used the following methods for gathering evidence for the review:

- An open consultation, which received 29 responses.
- 25 individual stakeholder meetings.
- Three roundtables.

Stakeholder meetings

	Organisation	Name and role
1	Cabinet Office	Cat Little, Permanent Secretary
2	Cabinet Office, Public Bodies Team	Lorna Horton, Deputy Director
3	Chartered Institute of Public Finance and Accountancy	Diana Melville, Governance Advisor
4	College of Policing	Chief Constable, Sir Andy Marsh QPM, Chief Executive
5	Confederation of School Trusts	Leora Cruddas CBE, Chief Executive
6	Government Internal Audit Agency	Harriet Aldridge, Chief Executive Karen Holland, Operational director
7	Home Office	Sir Matthew Rycroft KCMG CBE, Permanent Secretary
8	HMRC	Angela MacDonald CBE, Deputy Chief Executive and Second Permanent Secretary
9	Infrastructure and Projects Authority	Nick Smallwood, Chief Executive
10	Local Government Association	Cllr Marianne Overton, Vice-Chair and Leader of the Independent Group Heather Wills, Principal Adviser – Finance and Governance
11	Local Government and Social Care Ombudsman	Amerdeep Somal, Ombudsman Nigel Ellis, Chief Executive
12	Lower Thames Crossing	Matt Palmer, Executive Director
13	National Audit Office	Gareth Davies, Comptroller and Auditor General
14	National Governance Association	Emma Knights, Chief Executive (to August 2024)

	Organisation	Name and role
15	NHS England	Amanda Pritchard, Chief Executive Professor Stephen Powis, National Medical Director Steve Russell, Chief Delivery Officer
16	NHS Greater Manchester Integrated Care	Mark Fisher CBE, Chief Executive
17	National Police Chiefs' Council	Chief Constable Gavin Stephens, Chair
18	Nottingham University Hospitals NHS Trust	Anthony May OBE DL, Chief Executive
19	Shrewsbury, Telford and Wrekin Integrated Care Board	Sir Neil McKay, Chair Simon Whitehouse, Chief Executive
20	UK Government Investments	Charles Donald, Chief Executive
	Individuals	**Name**
21	Independent reviewers into public service failures	Dr Bill Kirkup CBE Ken Sutton
22	Independent reviewer into public service failures	Baroness Casey of Blackstock
23	Author of Independent Review of Governance and Accountability in the Civil Service	The Rt Hon Lord Maude of Horsham
24	Former Parliamentary and Health Service Ombudsman	Sir Rob Behrens CBE
25	Academic	John Bowers KC, Principal of Brasenose College, University of Oxford

Roundtables

1	Sponsorship officials from a range of government departments (hosted by Cabinet Office ALB sponsorship team)
2	Working level branch of Cross Government Complaints Forum
3	Chief Executives and Chairs of public bodies (hosted by the Association of Chief Executives and the Public Chairs' Forum)

Committee on Standards in Public Life
1 Horse Guards Road, London, SW1A 2HQ
March 2025