Witness Name: Judith Smith
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THIRLWALL INQUIRY

WITNESS STATEMENT OF PROFESSOR JUDITH SMITH
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I, Professor Judith Smith, will say as follows: -

1. I am Professor of Health Policy and Management at the Health Services Management Centre (HSMC) in the School of Social Policy and Society at the University of Birmingham, a post I have held since 2015. I am also Director of Health Services Research with Birmingham Health Partners, Trustee and Chair of Health Services Research UK, Visting Senior Fellow at the Health Foundation and Senior Associate of the Nuffield Trust.

2. I have worked in health services research, evaluation and development since 1995, following an earlier career as a senior manager in the NHS in Solihull and Coventry and having completed the NHS Graduate Management Training Scheme. My research and teaching focus on the organisation and management of primary and integrated care, evaluation of new models of care, healthcare management and organisational governance. I am co-author of one of the main international textbooks on health management (with Professor Kieran Walshe), and I have published extensively for practitioner, policy and academic audiences.

3. From 2015-2022 was I was the Director of HSMC and a member of the University's Leadership Forum. Prior to this I spent over six years as Director of Policy at the Nuffield Trust, a charitable independent health research foundation in London. From 1996 to 2009 I was employed by the University of Birmingham as a Fellow and then Senior Lecturer at HSMC, and from 2007-2009, was seconded on a research fellowship to the Health Services Research Centre of Victoria University of Wellington New Zealand and working as a part-time policy advisor in the New Zealand Ministry of Health.

4. From 2014-2022, I was a Non-Executive Director of Birmingham Women's and Children's NHS Foundation Trust, and from 2020 to 2024, Deputy Director of the Health and Social Care Delivery Research Programme of the National Institute for Health and Care Research. From 2010 to 2013 I was expert adviser on NHS organisation and commissioning to the Mid-Staffordshire NHS Foundation Trust Public Inquiry and an assessor of the inquiry's recommendations. In 2000 I prepared expert evidence (with Professor Chris Ham) on NHS management and culture for the Bristol Public Inquiry into paediatric cardiac surgery.

Introduction

5. I have been given the opportunity by the Inquiry team to submit supplementary information setting out my views about two documents published since the submission of my first statement of evidence to the Inquiry on 7 June 2024 (referred to hereafter as 'my first statement'). These documents are:

    i) the Department of Health and Social Care's proposals to establish a system of regulation of NHS managers ('the DHSC proposals'); and

    ii) the House of Lords' Statutory Inquiries Committee's report on public inquiries which has a particular focus on the implementation of recommendations made by inquiries.

6. The purpose of this statement is to set out my views about these two documents. The DHSC proposals are relevant to the comments I made about the oversight and regulation of NHS management and leadership in my first statement. The House of Lords' Inquiries Committee's report is relevant in helping to understand why Inquiry proposals are not always implemented, a topic I also examined in my first statement.

Oversight and regulation of NHS management and leadership

Consultation on proposals to regulate NHS managers

7. On 24 November 2024, the Department for Health and Social Care [DHSC] issued a consultation document 'Leading the NHS: proposals to regulate NHS managers' [1]. This document was described by Wes Streeting, Secretary of State for Health and Social Care, in a statement on 26 November 2024 as being part of a 'wider

programme of leadership and management development work to equip the NHS with the leaders needed to deliver the Ten-Year Plan' [2].

In the 12-week consultation period the DHSC seeks views on:

(i) the type of regulation;
(ii) which managers should be in scope;
(iii) what type of body should exercise a regulation function;
(iv) the types of standards that managers should be required to demonstrate; and
(v) how the introduction of a system of regulation might be sequenced.

8. The context for the consultation is described as actions following various inquiries and reviews, including

(i) the Francis Inquiry (particularly as to the 'Fit and Proper Person Test') [3];
(ii) The Messenger and Pollard Review (particularly as to 'new management and leadership standards to enable improved culture') [4];
(iii) The Infected Blood Inquiry (which recommended that senior leaders and board members should have a Duty of Candour apply to them as individuals) [5]; and
(iv) The Darzi Review 2024 (particularly the importance of investing in effective management and leadership) [6].

The purpose of the consultation is summed up by DHSC as follows:

> 'Regulatory oversight of NHS managers will provide an opportunity to further professionalise the NHS management and leadership workforce by setting clear and consistent standards that all managers and leaders in the NHS must meet. It will also strengthen their professional accountability by providing a consistent and fair means of addressing concerns about their conduct or performance and, in the most serious cases, will mean that an individual can be prevented from working in any NHS managerial or leadership role.'

9. The importance of 'right touch regulation' is underlined in the consultation, this being a term drawn from the work of the Professional Standards Authority (PSA) [7], the body that oversees health and social care regulators in the UK. Right touch regulation highlights the need to balance 'risk against regulatory force' [7].

10. A range of potential benefits of regulation of NHS managers are set out in the DHSC consultation, for example:

    (i) public protection,
    (ii) professional accountability, and
    (iii) fair treatment.

11. Other issues are considered as potential downsides of regulating NHS managers, including barriers to entry to the profession, a 'chilling effect' linked to fear of sanctions, and the possibility of vexatious complaints.

12. Four possible approaches to the operation of regulation of NHS managers are suggested in the document:

    (i) statutory barring mechanism;
    (ii) professional register;
    (iii) full statutory regulation; and
    (iv) accredited voluntary register.

    Views on each of these are sought as part of the consultation.

Key considerations

13. Drawing on the analysis in my first statement, I consider the following issues to be of particular importance within work that should be undertaken to establish a system of regulation of NHS managers:

    (i) That a system of regulation of NHS managers is put in place this time. It is almost 25 years since such a system was first proposed by Sir Ian Kennedy [8].
    (ii) That the system of regulation should comprise clear measures that go beyond policy exhortations.
    (iii) That the approach is proportionate (or indeed 'right touch'), striking a balance between regulation, barring, standards and accountability on the one hand, and codified behaviour, training and development, and professional support networks on the other.

(iv) That regulation is advanced as having the potential to support managers and leaders in feeling more able to speak up about matters of safety and quality of patient care, especially when these conflict with other organisational, policy or political priorities. The ability of managers and leaders to speak up is just as important as that of the clinicians and other staff who will speak up to them, thus helping to enable more open, psychologically safe and just cultures.

(v) That a code of conduct for NHS managers forms the core of any approach to regulation, along with clearly defined standards of management and leadership. This should be enshrined in employment contracts. As set out in my first statement, this could helpfully draw upon:

(a) the 2002 code of conduct for NHS managers [9],
(b) the Nolan principles of public life [10], and
(c) Professor Don Berwick's principles for leading a high-quality and safe health system [11].

(vi) That a code of conduct and associated standards be regularly and formally reviewed and updated by the chosen regulatory body, in the way that other professional regulators do. This would reduce the risk of the 'policy thicket' [12] of serial and overlapping sets of guidance about leadership and management that lack formal status.

(vii) That a commitment be made to a significant investment in the training and development of all NHS managers, in particular (as proposed by Messenger and Pollard) [4] at the point at which they take up their management role, then mid-career, and later when aspiring to an executive or board role. Such training and development could become a core part of a system of continuing professional development required of NHS managers and leaders as part of their registration.

14. In my first statement, I noted the lack of a formal professional membership body to which all NHS managers are expected to belong, a body which could perhaps accredit management and leadership programmes and courses, provide networking, mentoring and support, and oversee career development, There is learning to be gained here from equivalent health management professional bodies in other countries, and in the UK from medical and other royal colleges. Any move to

establish regulation of managers could helpfully include the establishment of such a professional body.

15. In terms of specific approach to regulation, I think this is for the NHS management community in partnership with DHSC and other key stakeholders to work out. As a minimum such approach should include a professional register (whether voluntary or compulsory), a code of conduct, a requirement for continuing professional development, and the use of the Fit and Proper Person's Test.

16. Sequencing the development of regulation of NHS managers (e.g. perhaps starting with board-level and those reporting to board level) would seem to make sense, as this is a significant cultural and professional change which will need careful design, implementation, evaluation and review, along with a significant investment in and commitment to the importance of professionalised NHS management.

17. As noted in my first statement, I consider that any system of regulation of NHS managers should apply to those senior managers (as well as board members) working in arms-length regional and national bodies such as NHS England and the Care Quality Commission, as well as to these roles in NHS provider and commissioning organisations.

Regulation of hybrid managers

18. The consultation acknowledges the complexity and importance of the approximately one-third of NHS managers who are clinically (e.g. medicine, nursing) or otherwise professionally qualified. It proposes three approaches to the regulation of managers who hold a clinical professional registration:

    (i) dual registration;
    (ii) broadening existing regulatory frameworks to include management competencies; and
    (iii) developing a set of mutually agreed standards between existing clinical regulators and the body responsible for regulating managers.

19. Given the complexity of holding a senior management or leadership role in a large healthcare organisation, and the need for all those in such roles to uphold common standards, access shared training and development, and be considered a single

management community, there are potential advantages of the first option (dual registration), together with option 3 (a set of mutually agreed standards of management and leadership) as a first step.

Implementation of pervious inquiry recommendations

The House of Lords Inquiries Committee Report

20. The House of Lords Statutory Inquiries Committee published its report 'Public Inquiries: enhancing public trust' [13] on 16 September 2024. The report explains its context as follows:

> 'too often, inquiries are failing to meet their aims because inquiry recommendations are not subsequently implemented, despite being accepted by the Government.'

The House of Lords Inquiry had as its core questions:

(i) How the Inquiries Act 2005 might be improved.
(ii) Whether statutory inquiries are as effective as they can be.
(iii) What challenges and risks they face, and how they might be improved.
(iv) Whether the system set up under the Inquiries Act 2005 is the best for running inquiries, and when other methods might work better.

21. For the purpose of this supplementary note to my first statement, I focus on what the House of Lords report concluded about the reasons why inquiry recommendations work or not.

22. The House of Lords Committee noted that the Government has a statutory duty to respond to a public inquiry, but no obligation to give reasons for accepting or rejecting recommendations. They also pointed to the lack of a formal framework for following up inquiry recommendations, resulting in too many recommendations 'withering on the vine' when accepted by Government. The Committee considered the following options for who should monitor the implementation of inquiry recommendations:

(i) Families and pressure groups.
(ii) The inquiry chair.
(iii) Parliament via select committees or similar.

(iv) Reconvening the inquiry within first 6 months post-reporting.

(v) Independent implementation monitors (an approach used in Australia).

(vi) Monitoring by supreme audit institutions (e.g. National Audit Office).

(vii) A new independent national oversight mechanism.

(viii) An enhanced Cabinet Office Inquiries Unit.

(ix) A new Public Inquiries Committee of Parliament.

(x) Research function to examine and follow up on themes and cross-cutting issues.

23. The House of Lords report concludes that:

> 'Insufficient implementation monitoring has damaged the reputation of public inquiries and made them less effective.'

The House of Lords Committee recommended that a new joint select committee of Parliament, a 'Public Inquiries Committee', be established along with some enhancing of the role, profile and functions of the Cabinet Office Inquiries Unit.

24. Having a joint select committee of this nature concords with my analysis in my first statement about the importance of robust and sustained follow-up of recommendations following an inquiry.

25. There would appear to be useful learning to be gained by any such committee from the independent implementation monitor approach used in Australia. This entails a senior independent figure being appointed to oversee and report to government on the implementation of recommendations from an inquiry [13].

Ways of trying to enhance the likelihood of successful implementation of inquiry recommendations designed to improve organisational culture.

26. In my first statement, I suggested some ways in which NHS inquiry recommendations might be shaped, implemented and followed up. As with the Institute of Government's evidence to the House of Lords and their report of 2017 [14], I concur that there are many examples of inquiry recommendations that have served to improve public policy and some have done so within the NHS. There are however more that have not been fully enacted, and the House of Lords Committee report highlights that these include many of those related to NHS culture which appear particularly resistant to change. This point was also made strongly by the Expert Panel of the House of Commons Health and Social Care Select Committee in 2024 [15].

27. As in my first statement, I consider that there is a need for inquiry recommendations to be crafted as a coherent set of interventions, of which each is clearly (in the words of my University of Birmingham colleague Professor Martin Powell) 'implementable rather than sermonising' [16].

28. Taken as a whole, recommendations aimed at improving organisational culture will need to address the critical components known (from inquiries and research evidence) to influence managerial and professional behaviour.

29. Implementable recommendations might therefore include (these are examples taken from my first statement):

    (i) Using research evidence on the progress to date of the Duty of Candour to adapt such a duty for the future, including how it should be implemented if applied to NHS managers and leaders (including non-executives) as individuals.
    (ii) Establishing a code of conduct for NHS managers, with an underpinning set of standards, embedded in employment contracts and a system of formal regulation of managers and leaders.
    (iii) Ensuring that the code of conduct, standards and regulation apply to managers within NHS England and other arms-length bodies as well as NHS trusts and integrated care boards.
    (iv) The use of these management standards to design, accredit and provide training and development to all managers and leaders (including non-executives), at critical points in their career, and within a system of compulsory continuing professional development.
    (v) Establishing a central source of funding for this training and development, to end the highly variable access for managers, and in particular those from clinical backgrounds.
    (vi) The development of a professional college or similar for NHS managers and leaders, to oversee educational and other standards, support professional development, and provide support and mentoring.
    (vii) Requiring that the set of management and leadership standards is formal and enduring and cannot be adapted or superseded without a formal process, thus avoiding the risk of 'policy thickets'.

(viii) Mandating a quality committee for all NHS trusts and foundation trusts and providing guidance on its membership and likely terms of reference, including the need for clinical non-executive membership.
(ix) Re-establishing the NHS Appointments Commission to oversee the recruitment, training, development and appraisal of non-executive directors and chairs.
(x) Setting out a formal process for monitoring the implementation of those inquiry recommendations accepted by Government.

Conclusions

30. Proposals about the development and regulation of NHS managers should be concerned with professionalising and supporting compassionate and accountable health management and leadership that has patient safety and care quality at its core.

31. The professionalisation of NHS management must be approached as a core part of strengthening both clinical and corporate governance with NHS trusts.

32. The impact of the complex and sometimes problematic wider NHS organisational culture examined in my first statement and in the review by Messenger and Pollard [4] (among others) is important context to any changes proposed.

33. Policy attention to the recommendations made by NHS inquiries should focus on three key themes:

    (i) the nature of the recommendations;
    (ii) how far they are implementable; and
    (iii) developing more robust and sustained formal mechanisms to follow up on recommendations that are agreed for implementation.

34. These two recent publications by DHSC and the House of Lords Statutory Inquiries Committee reveal the ways in which political and policy debates about NHS management culture and the role of public inquiries are both very live and highly relevant to the work of the Thirlwall Inquiry. I consider that these two publications complement and extend some of the analysis that I made in my first statement.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.

PD

Signed: _____

Dated: _____3 January 2025_____

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