HTA Board meeting, 27th June 2024

Agenda item	4.3 Living our organisational values: Reflections on recent reports into managing the personal impact of regulatory decisions and actions
For information or decision?	Information
Decision making to date?	N/A
Recommendation	N/A
Which strategic risks are relevant?	Risk 1: Notable regulation failure leading to public harm and/or loss of public/professional confidence in the HTA Risk 2: Misperception of the HTA's role and reach or poor external relationships leading to gaps in sectoral risk management
Strategic objective	Approach to Regulation
Core operations / Change activity	Core operations
Business Plan item	Regulation – fulfilling our licensing, inspection, incident management and approvals functions, providing technical advice and superintending compliance across the sector
Committee oversight?	N/A
Finance and resource implications	Limited
Timescales	Ongoing over the course of 2024/25
Communication(s) (internal/external stakeholders)	Yes
Identified legislative implications	N/A

Living our organisational values: Reflections on recent reports into managing the personal impact of regulatory decisions and actions

Background

1. The HTA has reflected on the lessons learned from the Ruth Perry case[1] which highlighted the potential for regulatory decisions and actions to have serious consequences, not least mental health crisis, for people impacted by regulatory processes.

2. Whilst not being complacent, following a review in light of the Ruth Perry case, the HTA has not identified similar issues of this nature. We have received good engagement and positive feedback on our inspection processes from our licensed establishments. They are given multiple opportunities to challenge the factual accuracy of our findings and to feedback on the inspection process. The context and processes surrounding HTA inspections are in many respects very different to those present in the Ruth Perry case.

3. Nevertheless, whilst the HTA does not believe that its regulatory approach suffers from the types of issue exposed in that tragic case, we believe it is important to critically assess our regulatory processes and how we engage with those whose work we regulate to identify any opportunities for improvement.

4. This paper:

    - provides a brief overview of information available in the public domain concerning this topic, including from Institute for Government[2], other regulators (Ofsted[3] and CQC[4]), and the Beyond Ofsted Inquiry (2023)[5];
    - outlines what considerations the HTA has given to this matter;
    - highlights those aspects of our new strategy that are most pertinent; and
    - sets out some practical steps, aligned to the HTA values and strategy, that the HTA will consider implementing to ensure we raise awareness of, and suitably mitigate the risks of, this type of issue arising in connection with carrying out our regulatory functions.

[1] Ruth Perry - Prevention of future deaths report (judiciary.uk)
[2] ofsted-inspection-reform.pdf (instituteforgovernment.org.uk)
[3] Prevention of Future Deaths Report (Regulation 28): Ofsted's response (publishing.service.gov.uk)
[4] CM240251 Item 5.1 OFSTED reports and implications for CQC (1).odt (live.com)
[5] Beyond-Ofsted-Report.pdf (beyondofsted.org.uk)

5. The Board is invited to note our recommendations for the steps we are taking, and aim to take, in response to our reflections on this important matter.

Organisational behaviour: aligning values and strategy

6. The published documents and reports relating to the Ofsted inspection which led to the tragic Ruth Perry case identify three main causes of concern and criticism, which can be summarised as:

    - the impact of a regulator's assessment or rating, including how any such assessment is determined;
    - process issues (such as strict confidentiality of draft reports, lengthy delays in finalising reports and no effective complaint process or escalation mechanism for those subject to inspection); and
    - poor standards of professional behaviour.

7. Over a similar period to our consideration of the Ruth Perry case and subsequent reports, the HTA has been creating its new 3-year strategy. The draft strategy explicitly links to our organisational values, ensuring they are embedded in all aspects of our work, including our operational interactions with those whose work we regulate.

8. The HTA considers that the main lesson to be learned from the Ruth Perry case is that there should be effective alignment between an organisation's espoused values, its defined strategy and its operational policy and practice, as how regulators work is as important as what and why they do their work.

9. The HTA's organisational values of Collaboration, Openness, Respect and Excellence, therefore, provide the 'how' ('how we work') for delivering the 'what' as defined under the four themes of our new draft strategy; Efficient and Effective, Approach to Regulation, Use of Information, and Trust and Confidence.

10. We have set out below the steps we have taken to carefully reflect on and consider these matters and how we propose to ensure that our behaviours as a regulator are aligned with our stated values and strategy.

HTA Actions to date

11. The HTA's Regulation Directorate has considered this topic over the past six months, including at two Regulation Training Days. We have reviewed information in the public domain (as referenced) and identified what the HTA does well and what it could change. Any potential changes identified are aimed

at ensuring our values and strategic objectives are better embedded into operational practice. This should enable us to continue to carry out our core regulatory functions in a way that is effective; protecting the public and public confidence whilst sensitively managing the potential personal impact on those we regulate.

12. The HTA has also compared notes with other regulators. We engaged with the CQC to learn about the additional actions they decided to put in place following the conclusion of the inquest for Ruth Perry, as referenced in a published paper from their February Board meeting.[6]

13. These deliberations have also been discussed by the HTA's Business Delivery Team and by the Senior Management Team.

14. The HTA's core regulatory processes, including regulatory compliance assessments ('inspections') do not have some of the key factors identified as contributing factors to the issues in the Ruth Perry case. Some of those distinguishing features are summarised below:

    - Our exception-based inspection reports assess compliance with specific standards, briefly setting out how any standards are not met ('shortfalls') and categorising those shortfalls in a standardised way (minor, major or critical), rather than an overall thematic assessment;
    - Draft inspection findings are always discussed at a closing meeting immediately after the conclusion of an inspection and whilst the Designated Individual (DI) is the person to whom that is directed, establishments are given the opportunity to (and in our experience do) invite a wide range of internal stakeholders to these feedback meetings;
    - Our service standards require draft inspection reports to be written-up, internally quality-assured and then sent to the DI (and the Corporate Licence Holder contact, CLHc) within 20 working days following the inspection, for factual accuracy checking by the establishment;
    - The DI is free to share the draft inspection report within their organisation (although not to publish it or make public comments on it) pending its finalisation and publication by the HTA, in line with our service standard.[7]

15. There is no project line or budget in the HTA's 2024/25 business plan relating to work on this topic. Hence, potential actions have been prioritised to identify those considered most pertinent and impactful and which could be taken forward

[6] CM240251 Item 5.1 OFSTED reports and implications for CQC (1).odt (live.com)
[7] The HTA aims to publish inspection reports within seven days of finalisation.

through our continuous improvement activity within core business, as set out below.

Next steps

16. The key areas identified for development and delivery over the course of the coming year are summarised, prioritised in terms of sequence of delivery, as follows:

    a) Staff training and awareness raising on relevant topics, including workplace stress, mental health awareness, embedding our values in how we work and how to hold difficult conversations;
    b) Internal guidance – being explicit about how to handle difficult conversations and how to give those we regulate the opportunity to raise concerns about how they have been dealt with;
    c) External guidance – to ensure those we regulate are clear about our values, our expectations, including what they can expect of us, their rights to challenge us and how to escalate concerns that may arise; and
    d) Improvements to the inspection feedback process to encourage participation by licensed establishments and to make this easier and more comprehensive for licensed establishments to complete.

Conclusion

17. The HTA believes the risk that our inspection and regulatory processes could trigger an issue of the type discussed above is very low, given:

    a) our inspection processes are very different from those highlighted in published material about the Ruth Perry case; and
    b) consistent feedback indicates our staff are highly professional and constructive in how they conduct their work, including, when necessary, imparting “bad news”.

18. However, we are keen to avoid any complacency and improve where we can, being guided by our values, to continue to enhance our approach to engaging with those we regulate, to reduce and mitigate the likelihood of unnecessary adverse personal impacts.

Recommendations

19. The Board is invited to note the work the HTA has identified we can do, focused on activities relating to regulatory compliance assessment (inspection), as set out above under “next steps”.