

A review of the Fit and Proper Person Test

Commissioned by the Minister of State for Health

by Tom Kark QC and Jane Russell (Barrister)

Contents

Contents	i
Foreword	1
Letter from Tom Kark QC to Minister of State for Health	1
Introduction	3
1. Executive Summary	11
2. The regulations, the problems and relevant issues	16
The Health and Social Care Act 2008 (Regulated Activities) Regulations	16
Who is covered?	18
Good character	19
Qualifications competence, skills and experience	20
Reasonable adjustments for health	21
Responsible for, facilitated, or privy to serious misconduct or mismanagement	21
Bankrupts and the DBS listed	22
Information to be available to the CQC	23
Action to be taken where requirements in subparagraph 3 are no longer met	24
Recommendations in relation to the regulation itself	26
3. The FPPT in previous reports	27
The Dalton Review	27
The Kirkup Review	27
Lord Rose’s 2014 Review of Leadership in the NHS	32
Ed Smith’s 2015 Leadership Review	33
The University of Manchester Report 2018	34
The King’s Fund Report on Leadership in the NHS 2018	40
Sir Ian Kennedy	42
Conclusion	42
4. THE CQC AND REGULATION 5	44
The role of the CQC	44
Well-Led Inspections	45
The CQC consultation in 2017	46
2018 CQC FPPT Guidance	46
To whom does the Regulation apply?	48
What constitutes a breach of the FPPR and how is it evidenced?	49
Systems, processes and information retained by trusts	50
Guidance on misconduct and mismanagement	51

Action the CQC can take	55
Conclusions and recommendations in relation to the CQC	61
5. NHS Improvement.....	63
Overview.....	63
Conclusions and recommendations.....	71
6. Management Qualifications and Training.....	72
Competence and qualifications – the lack of transparent competencies, assessment and training for the Board	72
Board development and appraisal	78
Revalidation.....	79
Conclusions and Recommendations	80
7. Extending the reach of the test.....	84
Commissioners, NHSE, CCGs and ALBs.....	84
Wales, Northern Ireland and Scotland.....	86
Other management positions.....	86
Regulators – CQC, GMC, NMC and others	87
8. Information and records about directors.....	88
The issue	88
Settlement agreements.....	91
References	91
Power of CQC to require information from service providers and others.....	95
Conclusions and recommendations.....	97
9. A power to disqualify.....	98
A power to disqualify directors guilty of serious misconduct.....	98
Definition of serious misconduct	101
A sanction regime	109
A time limit.....	109
The HDSC	110
Conclusion and recommendations	110
10. Settlement agreements and confidentiality clauses	112
What is a settlement agreement?	112
The problems with settlement agreements and the FPPT	112
Overview and recommendations	117
11. What other regulators and organisations do.....	118
Introduction.....	118
Overview.....	124
12. Social Care	126

13. Recommendations	127
Recommendation One.....	127
Recommendation Two.....	128
Recommendation Three	130
Recommendation Four	131
Recommendation Five.....	132
Recommendation Six	134
Recommendation Seven	134
Recommended amendments.....	135
Appendix 1	136
Morecambe Bay Investigation report;	136
Appendix 2	137
Appendix 3	138
Mandatory Reference Form.....	138

Table of Abbreviations

2014 Regulations	Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
ALB	Arms-length body
CQC	Care Quality Commission
DHSC	Department of Health and Social Care
GMC	General Medical Council
FPP	Fit and Proper Person
FTs	Foundation Trusts
FPPR	Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
FPPT	Fit and Proper Person Test
GDC	General Dental Council
HCPC	Health and Care Professions Council
HDSC	Health Directors' Standards Council
HSCA	Health and Social Care Act 2008
IOD	Institute of Directors
KLOE	Key Lines of Enquiry
NED	Non-Executive Director
NGO	National Guardian's Office
NHS	National Health Service
NHSE	NHS England
NHSI	NHS Improvement
NHS TDA	NHS Trust Development Authority
NHS TDA Directions 2016	NHS TDA Directions and Revocations and the Revocation of the Imperial College and the Revocation of the Imperial College Healthcare NHS Trust Directions 2016
NMC	Nursing and Midwifery Council
NTP	National Talent Pool
PSA	Professional Standards Authority
SUG	Speaking-Up Guardian

Foreword

Letter from Tom Kark QC to Minister of State for Health

November 2018

Dear Minister,

In July of this year your predecessor, Stephen Barclay MP, commissioned me to write a report and to make recommendations in relation to the Fit and Proper Person Test (FPPT) as it applies under the current Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The time in which I was to receive evidence and write a report was short, being instructed to report this Autumn and, by necessity, my work has taken the form of a rapid review. My report is focussed upon that which I feel is necessary now as it relates to the position of Board level directors in provider Trusts. I have left the way open to consideration being given as to the workings of the test as it relates to the provision of social care which is a very substantial issue.

It was obvious that there was a widely-held perception that the test under Regulation 5 was not working effectively. An examination of the test was recommended by Dr Bill Kirkup in his report into the problems at Liverpool Community Health Trust.

I came to this task with an open mind and have consulted extensively. My recommendations are based upon the information with which I have been provided. I have had access to every part of the NHS across all levels of seniority where I have been welcomed and greatly assisted.

During the course of the review, I have tested my recommendations in broad terms with the senior management of the NHS to try to ensure that any proposals would be workable in practice. Although I have been pressed to widen my recommendations, I have resisted that temptation, but again left the door open to further consideration should the current recommendations not perform the job needed to be done.

The recommendations, which I very much hope are taken as a whole, are the sole result of my review of the material and the evidence I have received, together with the enormously helpful input of Jane Russell, a barrister specialising in employment law, who has assisted me. We have also had great support and help from Stephen Rippon and Christopher Page of the DHSC.

A REVIEW OF THE FIT AND PROPER PERSON TEST

I am grateful for having had this opportunity to review an important piece of legislation affecting the management of one of the most accessible and best public health systems in the world.

Yours sincerely

A handwritten signature in blue ink, appearing to read "Tom Kark", enclosed in a thin black rectangular border.

Tom Kark QC

Introduction

1. I have been asked to review the Fit and Proper Person Test (FPPT), set down by Regulation 5 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as it applies to directors within the health service in England. I have been involved in the world of medical regulation as a barrister for over fifteen years and I was counsel to the Mid Staffordshire NHS Foundation Trust public inquiry. Jane Russell who has assisted me has been a barrister specialising in employment law for 14 years and, before that, a solicitor for 5 years. We have also been greatly assisted by Stephen Rippon, Chris Page and Jon Smith from the Department of Health and Social Care who have provided secretariat services but have not had any direct influence upon this report. 'We' from here on refers to Jane Russell and myself.
2. The NHS directly employs over 1.2 million staff and, in total, is allocated over one hundred billion pounds of taxpayer's money annually. The quality of management within the NHS is an issue of considerable national importance. The behaviour and ethos of staff within our hospitals are often heavily influenced by the behaviour and ethos of the directors on the Trust Board and especially those of the Chief Executive and the Chair.
3. No hospital can run well with poorly led medical staff who do not or cannot focus on the care of the patients as being their first concern. Good hospitals run well because they have good, focussed leadership and well-trained and enthused staff who are enabled to focus on providing good, safe and compassionate care for their patients. We are well aware of the extremely tight financial constraints upon the system and the fact that many hospitals struggle to provide the quality and quantity of care required by their populace within the financial envelope provided. However, the limited purpose of this review is to focus upon the Fit and Proper Person Test (FPPT), to determine whether or not in its current form it is working, and how it might be adapted to ensure better leadership and management and prevent the employment of directors who are incompetent, misbehave or mismanage.
4. In his report into the Mid Staffordshire NHS Foundation Trust, Sir Robert Francis QC made a large number of recommendations to the government. Some of those recommendations were directly relevant to the role of senior management in hospital Trusts. During the course of the public Inquiry into Mid Staffordshire another scandal was investigated, that at the Winterbourne View Hospital. The management of hospitals caring for patients was placed front and centre of the national debate in relation to health care.
5. One of the identified problems relating to management in relation to those two organisational failures was the ability of poorly performing managers and directors to move from Trust to Trust, often following a settlement agreement and a pay-off. As Sir Robert Francis QC set out in his executive summary at 1.144:

“There has been understandable concern at the circumstances surrounding the departure from the Trust of the Chair and Chief Executive. While the business demands of the Trust may have required their swift departure and therefore a commercially understandable compromise, the public demand for accountability was left unsatisfied.

A REVIEW OF THE FIT AND PROPER PERSON TEST

Directors should be liable to disqualification from the role unless they are Fit and Proper persons for it.

The test of fitness should include a requirement to comply with a prescribed code of conduct. A finding that a person is not a Fit and Proper person should disqualify a person from being a director of any healthcare organisation. Where a regulator is no longer satisfied that a director is a Fit and Proper person, there should be a power to remove or suspend that person from office after due process. Where a director's employment or appointment is terminated in circumstances where there is reasonable cause to suspect he or she is not a Fit and Proper person, the organisation should be obliged to report that information to the regulator."

6. Following the Mid Staffordshire report the government published its response 'Hard Truths'. The government accepted the recommendations made and in relation to the issue of management gave the following assurances:

Para 53. "There will be a new stronger Fit and Proper persons test for Board level appointments which will enable the Care Quality Commission to bar directors who are unfit from individual posts at the point of registration. This will apply to providers from the public, private and voluntary sectors. The Government believes that the barring mechanism will be a robust method of ensuring that directors whose conduct or competence makes them unsuitable for these roles are prevented from securing them. The scheme will be kept under review to ensure that it is effective, and we will legislate in the future if the barring mechanism is not having its desired impact."

Para 54. "There must also, on occasion, be direct consequences for senior managers for failures in their organisations. NHS Employers will therefore be commissioned to work with the Care Quality Commission, the NHS Trust Development Authority and Monitor to develop guidance to support the effective performance management of very senior managers in hospitals through appraisal and other means, including linking the Chief Inspector's ratings to individual contracts."

7. We have no doubt that these promises were well intentioned. However, the reality is that the legalisation as enacted and brought into effect did not create a barring mechanism nor (rightly in our view) were the Chief Inspector's ratings linked to individual contracts. The CQC was not given the power to 'bar directors'. Indeed, the CQC has no direct power over individual directors, has never had such power, has never sought such power, and is not structured so as to be capable of undertaking the task. The CQC in general regulates organisations and not individuals. It does not directly regulate individual directors within Trusts and has no power to do so.

A REVIEW OF THE FIT AND PROPER PERSON TEST

8. The CQC accordingly was unequipped to fulfil the government's assurances made on its behalf and the task of acting upon the Fit and Proper Person test was left to the Trusts themselves. There is good reason, in fact, to ensure that it is always the Trust itself which is responsible for its own appointments. Removing that responsibility and handing it over to an independent regulator would diminish the responsibility of the Trust to ensure that its management was properly organised so as to protect and care properly for its patients. Although we have been urged by some groups to recommend the setting up of a brand-new, director-focused regulator to oversee and regulate the appointment and continued employment of Trust directors, the effect of doing so would in our view risk creating a new problem of devolving or diminishing responsibility from Trust Boards for their own appointments. Would the regulator be responsible for such failure or the Trust Board? It is not difficult to foresee that, unless great care was taken, such a tension could be a flaw for this model. Although we have drawn back from recommending the creation of a regulator in that form, we do accept that that position should be kept under review and an assessment of the success or failure of our current recommendations (if accepted) will in due course have to be made.
9. Our review has also had to grapple with some fundamental issues, which may be well known to those working within the NHS and to the Department of Health and Social Care but appear to be insufficiently understood either by wider government or by the public. The first is that the NHS is not, as some might think, a centrally organised and ordered system. Although it is a 'national service' it is only loosely governed by the Department of Health and Social Care. Each NHS Trust, whether it has converted to Foundation Trust status or not, is, in effect, an independent body or business, independently run by its Board and its Chief Executive.
10. The vast majority of the money to run the business comes from central government and so a government minister is in charge of that budget but the government, through the Secretary of State for Health, only provides sets the goals which are to be achieved. How each hospital reaches those goals is largely independently decided by the Board¹ of each Trust. The culture and management of each hospital Trust flows from the management team. Thus, the quality and culture of the management team is of the greatest significance to the ethos and success of the hospital, the effectiveness and the working conditions (in the widest sense) of its staff, and ultimately the care, comfort and safety of the patients to whom the Trust provides health services.
11. It is for that reason that the Fit and Proper Person test, which is supposed to apply to senior management, i.e. Board Directors, (both executive and non-executive) and those performing equivalent roles, should be of the greatest significance and capable of being a profound force for improvement. At present, it is not, because it is not properly applied in every Trust. At this and every stage we should apologise to the great majority of Trusts whose Boards and Chief Executives, Chairs and Directors perform an outstanding job, with determination, insight, self-reflection, with a careful view as to the effectiveness of the Board's function, and often, if not always, in challenging financial circumstances. In our recent perambulations around the NHS we have been honoured to meet outstandingly

¹ However, the authors of the 2018 Manchester University report (Chambers et al) opined: "NHS Boards are odd creatures of corporate governance – even Foundation Trusts are not autonomous – the government role of central control is very powerful and this has also arguably got tighter over recent years".

A REVIEW OF THE FIT AND PROPER PERSON TEST

committed and clever people determined to improve the care of the patients in their Trusts. There are however exceptions.

12. The lack of central control has also led to a startling lack of information about the people who manage health Trusts at director level. There are only 229 Trusts in England, each with an average of 12 directors on the Board. Therefore, there are likely to be fewer than 3000 directors on NHS Trust Boards and, even counting those directors who have left the system but may return, there will be fewer than 3,500. However, there is no centrally-held list of who is the Chief Executive or Chair of each Trust or who comprises the Board of each Trust. There is no background information kept in relation to Board members: where they have been; what their qualifications and training are to equip them for the role they are appointed to undertake; what their management history has been and where they have failed or succeeded (however success or failure is measured). There is no compulsory or comprehensive training either at CEO level or at Board level, no accreditation, no comprehensive scheme of continuous development or 360-degree assessment. Anyone with almost any background, provided they are not on the barred list managed by the DBS², a person convicted of serious crime or an undischarged bankrupt could apply for the post of an executive or non-executive director (NED) of a Trust.
13. It may well be that a significant majority of Trusts are well managed by qualified, suitable and competent people. We put it as conservatively as that because in 2018, of those Trusts inspected by the CQC, 72%³ of them received a 'good' score or above in respect of 'Well-Led'⁴. However, that there are clearly also a number of Trusts which are less well managed or struggle despite good management.
14. Mid Staffordshire was unfortunately only one of a long list of hospitals (Morecambe Bay NHS Trust, Gosport War Memorial Hospital, Liverpool Community Health NHS Trust, Winterbourne View Hospital) publicly shamed, which have had significant problems delivering good care, a factor in each being a failure or failures of management. Although great steps have been taken to improve the culture of providing care within the NHS the reality is that the steps taken to deal specifically with failures in management have been less effective than they should have been.
15. Dr Bill Kirkup examined the failure at Liverpool Community Health NHS Trust and we have examined his report carefully in [Chapter 3](#). The essence of the failure however was one of poorly trained management resulting in poor management and a focus upon costs rather than patient care.
16. He found many of the failures that had beset Mid Staffordshire were replicated at Liverpool. It was frankly depressing to read such a similar list of failures which Sir Robert Francis had examined in Mid Staffordshire occurring again in Liverpool several years later.
17. The failures were all indicative of an abject lack of management ability coupled with a loss of focus upon what must always be the central goal of any hospital Trust which is to provide safe, quality care for its patients and ensure they are protected.

² Disclosure and Barring Service

³ Figure 1.6 "NHS Acute key question ratings at core service level for 31 July 2018". State of health care and adult social care in England 2017/2018; CQC; 2017.

⁴ Further, Trusts received a 'good' rating and above for the following areas: 58% for 'safe', 79% for 'effective', 98% for 'caring' and 69% for 'responsive'.

A REVIEW OF THE FIT AND PROPER PERSON TEST

18. However, the failures also signal an even deeper fault in the service more widely. That is the lack of required, adequate, quality training as to what the function of a Board is, how a good Board operates, what a good Board 'looks like', how to be an effective Board member, how to ensure there is independent analysis and assessment of the Board function and to provide support and training where required.
19. The timing of these events is of course relevant. All of the failures referred to occurred before the enactment of the Fit and Proper Person test which came into force on 27 November 2014 but, for the reasons which follow in this review, there is no room for complacency or for the unwarranted belief that the Fit and Proper Person test has cured those problems. The failure of care at Liverpool took place primarily between 2010 and 2014 and this was the period covered by Dr Kirkup's terms of reference. The CQC inspected in 2013 revealing significant failures.
20. It is right to say that from that point on, the Trust received significant attention. The Trust Board sought to address issues raised in the CQC report by commissioning a quality, safety and management assurance review, carried out by Capsticks Solicitors LLP and that report was published on 22 March 2016. The Capsticks' report generated a sustained level of concern about the management culture of the Trust and practices demonstrated by senior managers and raised questions about the quality of the healthcare being provided by the Trust to patients in the community and in HMP Liverpool. Dr Kirkup was then commissioned by the Trust's new Chief Executive to undertake [a wider review](#) of the care provided by the Trust.
21. We would respectfully commend the reader to reread Dr Kirkup's findings set out from para 3.22 onwards with respect to the culture and leadership of the organisation which identifies a series of failures in the ethos, culture, and operation of the management of the services.
22. In Chapter 4, Dr Kirkup focused specifically upon the management of the Trust. We have taken the liberty of directing readers to chapter 4 of [Dr Kirkup's report](#) for ease of reference. It is required reading. It is only fair to comment that the new Board of that Trust was set up during a time of NHS transformation including the abolishment of Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs). Nevertheless Dr Kirkup summed it up as follows:

“There are lessons here that need to be learned. LCH [Liverpool Community Health Trust] was newly created; it had come from a very different organisational model within a PCT [Primary Care Trust]. It had an inexperienced Board, a chief executive in their first chief executive post, and external appointments to director posts with little or no experience of both the NHS and community services. And this was happening amidst a national organisational redesign. We believe that these factors indicated a sufficient level of risk to warrant special attention being given to the Trust. This does not seem to have happened.”
23. Dr Kirkup's recommendations are highly relevant to this report. Specifically recommendation 1 (at 6.1 [of his report](#)):

“In approving Trust Board appointments, NHS Improvement should take note of the level of experience of appointees and level of risk in the Trust, and should ensure a system of support and mentorship for Board members where indicated. Action: NHS Improvement.”

And 5 (at 6.5 [of his report](#)):

“The Department of Health should review the working of the Care Quality Commission Fit and Proper Person’s test, to ensure that concerns over the capability and conduct of NHS executive and non-Executive Directors are definitively resolved and the outcome reflected in future appointments. Action: Department of Health.”

24. With profound respect to Dr Kirkup whom we met and was of great assistance in the course of this review, in this very recommendation, which was to prove the embryo of this report, he fell into one error in the phrasing of that important paragraph in this way – the test is not ‘the CQC Fit and Proper person test’. It is a test to be applied by the Trust Board, the process being checked by the CQC as one part of their ‘Well-Led’ reviews. This is not just a semantic difference, it underlines why others have criticised the CQC for their ‘operation of the test’ when in reality it is not theirs to operate. This underlines the fundamental issue: who is it who reviews the quality of the decision (rather than the process) by which a Trust Board appoints a director who has to meet the Fit and Proper Person test?
25. This review was borne from that recommendation, but that recommendation should not have been necessary had Sir Robert’s recommendations around management and training been fully implemented. Nevertheless, the failure to follow those recommendations as effectively as they could have been has given the opportunity to consider again, now, where is the NHS in terms of the ability to remove directors guilty of serious misconduct or mismanagement using the Fit and Proper Person Test and how is that part of the test requiring directors to have the right qualifications and competence applied in practice? What mechanisms are there to ensure that directors have received the right training and have the right qualifications and competence to provide a high level of management expertise and how can things be made better?
26. It would be relatively easy to reinforce the Fit and Proper Person Test by setting the hurdle even higher and by prescribing further tests by which a director can more easily be excluded or permanently barred from director-level appointment. However, a fundamental problem which we have heard time and time again, is that there is a dearth of suitably qualified people willing to apply for jobs at the most senior executives in NHS Trusts. That is despite what should be the prestige of holding such a post and the considerable salary which attaches to the most senior positions. The reality is that, despite the importance of the job, many regard it as a poisoned chalice both because of the stress which attaches to the job of senior executive in an NHS Trust and because of the surprising lack of security of such posts. One information provider (IP) described the job of Chief Executive of an NHS Trust as “**being given a lightning rod and then told to go out and play in the storm**”.

A REVIEW OF THE FIT AND PROPER PERSON TEST

27. The 'churn' of Trust directors is also extraordinary high and the average term expectancy for a Trust Chief Executive is less than three years. A King's Fund Review in 2014⁵ found that 7% of all CEO positions were reported as unfilled; and the average tenure was 700 days. A more recent King's Fund report published in July 2018 revealed much the same pattern reporting that:

"Leadership vacancies in NHS Trusts remain widespread with 37 per cent of all surveyed Trusts having at least one vacant post for a Board-level executive. The highest vacancy rates were for director of operations and director of strategy roles."

28. Although it would be easy to recommend a higher hurdle, a strengthened test and an easier way of removing senior management, that would do very little to improve the perceived quality of the job of managing a Trust and might, quite easily, make the job even less attractive.

29. A system has to be devised to ensure that those who take on the role of senior management at Board level in the NHS are equipped with the skills necessary to undertake that important function; that they can be critically assessed to ensure they have those skills; that such assessment is continuous throughout their career; that they can be supported where appropriate to improve their skills; that they are supported and receive further training if things go wrong or if they are found not to have all the skills necessary. By requiring directors to have the necessary skills and competencies, and by providing them with training where they lack those skills, we hope that the job of Director would be made more attractive and better shielded from the slings and arrows of political interference.

30. However, there are cases where directors commit serious acts of misconduct or mismanagement and yet are able to move from one Trust to another. Sometimes they are quietly moved on, sometimes to another well-paid post within their own trust or through the 'revolving door', into another section of the NHS or another Trust. Sometimes a settlement agreement and a pay-out are involved together with a bland agreed reference and the wrongdoing is hushed up by a confidentiality clause. The can is thus kicked down the road to become a problem for the next Trust along. This situation is very different to that of the less than competent director who can be rehabilitated. When serious misconduct occurs, rare though it is, there must be a system of ensuring that the individual is barred from working in the health service. That is what the Fit and Proper Person Test was originally advertised to do. We have tried to devise recommendations which, if accepted, will make that a reality.

31. We have made extensive use of previous reports which have been published and which are relevant to the issues we have been asked to consider. If there were a collective noun for reports it might well be 'a fatigue' and we are acutely conscious that we are adding to the pile of reading for Trust Boards which are already massively overburdened with reports and guidance. We can only apologise and we have tried to make this report as succinct and readable as possible and with as few recommendations as seemed sensible and sufficient to do the job.

⁵ Leadership vacancies in the NHS, The Kings Fund (p19); December 2014

A REVIEW OF THE FIT AND PROPER PERSON TEST

32. In this report we will refer to all those who might be called 'service users' of a Health Trust as 'patients' and to all NHS Health organisations whether they are Foundation Trusts (FTs) or not, as Trusts. We have referred to all those who provided us with evidence and material as 'Information Providers' or 'IPs'.

TOM KARK QC & JANE RUSSELL
November 2018

1. Executive Summary

- 1.1 Our extensive reading and discussions have revealed few fans of the Fit and Proper Person Test (FPPT) as it is currently applied. There is a recognition that it does not do everything (some would say anything) that it holds itself out to do and some regard it as simply a distraction or a tick box exercise, just another hoop to go through which has no real effect on patient care or safety. Essentially it does not ensure directors are fit and proper for the post they hold, and it does not stop the unfit or misbehaved from moving around the system.
- 1.2 The following summarises just some of the issues raised about the FPPT and how it is applied and tested:
- (a) The test is applied fairly vigorously on the ‘barn door’ issues such as bankruptcy, DBS and convictions, but considerably less vigorously (or not at all) on other important aspects such as whether the director has the competence, experience and qualifications to perform the role;
 - (b) The test of qualification and competence has no criteria attached to it and so is a sliding subjective test depending on the need of the provider to appoint a director;
 - (c) Whether the test is reapplied or reassessed during the course of a director’s career depends on the vigour of the Chair, Chief Executive or a human resources director. There is no specific criteria to assess competence and qualifications, and so identification of a gap in those is harder to identify, even where Trusts are proactive about Board development and assessment, which some are not;
 - (d) The CQC when inspecting each Trust on a ‘Well-Led’ review will examine the Trust’s processes and systems for arriving at the decision that a director is a fit and proper person, but the CQC does not look at the quality of the individual nor whether they are in fact a fit and proper person for the role in which they have been employed;
 - (e) The FPPT only applies to providers in England – and so does not prevent directors who have ‘failed’ from moving into commissioning, improvement or education roles within the NHS at director level or to the health service in another jurisdiction;
 - (f) There is no central database and thus no accessible continuous history of each director which means that each Trust has to acquire that information afresh for each director upon appointment;

A REVIEW OF THE FIT AND PROPER PERSON TEST

- (g) The quality of information retained by each Trust about each director and in support of its decision on the FPPT is of very varying quality and is sometimes non-existent;
- (h) References, a critical tool to assess how an individual has acted in their previous employment, are too often 'vanilla' in content. The information in a reference which leads into the application of the FPPT can, in reality, be significantly lacking in important information;
- (i) Compromise, confidentiality and settlement agreements can lead to an agreed reference which fails to disclose the full background to the director's departure from the previous Trust even where misconduct has been involved;
- (j) Directors who have been shown to have committed serious misconduct at a Trust have nevertheless obtained further director level jobs within the NHS whether in a Trust or some other part of the organisation; there is currently no power to disbar a director who has been proved to have committed serious misconduct;
- (k) Trusts are sometimes required by a FPPT reference to examine the past behaviour of a director when he or she was working at a different Trust, relating to incidents which happened years before;
- (l) The test can be misused by Trusts when it suits them by tracking back to old complaints and using the FPPT as an add-on to a disciplinary process;
- (m) Parts of the test are unclear and difficult to apply with any rigour.

1.3 Our recommendations in relation to the operation of the test have been designed to address the core problems identified above. The recommendations are designed to work together, with each part necessary to the proper functioning of the others. We have deliberately separated the issues of the competence and qualifications necessary to be a director, from the issue of whether a director has been guilty of serious misconduct.

1.4 We make five core recommendations each with a number of subparagraphs.

1.5 It is central to these recommendations that the assessment of whether a director has the necessary skills and competencies for his or her role is made easier by the creation of a list of what the NHS considers the critical competencies of a senior executive director working in the health service to be. Further, training and development should be easily available to fill any gaps in knowledge and skills wherever they are found.

A REVIEW OF THE FIT AND PROPER PERSON TEST

- 1.6 The availability of good, comprehensive information about each director in the health system, which is not constrained by poor, uninformative references nor by settlement agreements restricting the information which can be passed from Trust to Trust, is also in our view of great importance.
- 1.7 Finally, it is, we believe, crucially important to distinguish the treatment of those directors who are not currently very good at the job (i.e. their competence is poor or the task too great) and who could, with support and/or training, become competent, from those who have been involved in serious misconduct. The less than competent or those struggling should be strengthened and helped with training, support and development. Those who have behaved in a way which is properly categorised as 'serious misconduct' should face the possibility of being barred from working at director level.
- 1.8 Our recommendations are therefore designed to cure the perceived problems by:
- (a) Requiring the design of a set of specific core elements of competence, which all directors should be able to meet and against which they can be assessed when considering whether they meet the FPPT in terms of qualifications, competence, skills and experience. The required competencies must embrace and cover the various different functions performed by different types of trust (e.g. hospital, mental health and ambulance). The duty of undertaking the assessment of whether each director has those skills is to be retained by the employing Trusts, but the quality of that assessment should be examined by the CQC which should have regard to the core competencies and to the evidence that exists as to whether or not the director meets them; no new appointments should be made to the post of Board Director (or their equivalent) unless the appointee concerned can demonstrate that they have, by experience or learning, acquired the core competencies;
 - (b) Setting up a central database so that information about directors is consistently retained and a history is built up in relation to each individual Board level director within the health service. The database would hold information about each director's current post, their qualifications and experience, as well as historic and current assessments and information about any upheld grievance or disciplinary matters. The submission of relevant material to the central database is a matter that will be relevant to the CQC's 'Well-Led' review of a Trust but the database itself should be held in one place to which limited organisations should have access;
 - (c) Requiring that a mandatory reference form be designed, which must be completed by the employer and signed off by a Board level director, when a director moves from health Trust to health Trust. The form would require full, open and honest information about the director concerned, which could not

lawfully be curtailed by the terms of a settlement or compromise agreement; where an employee is entering the health service for the first time or coming from a post which was not at director level, the new employing Trust must nevertheless make every practical effort to obtain such a reference which fulfils the mandatory requirements;

- (d) Extending the concept of the FPPT to Board level directors of commissioners and appropriate NHS Arms' Length Bodies (ALBs).⁶
- (e) Setting up a body which has the power to bar directors where serious misconduct is proved to have occurred. We have suggested that this body be called the Health Directors' Standards Council (HDSC) and that it should have the powers to investigate, require the production of information and, following a fair hearing, to bar directors from director level appointments in the health service;
- (f) Requiring the identification and definition of what is regarded as 'serious misconduct' justifying barring. This should focus upon deliberate or reckless but not inadvertent behaviour. Apart from obvious misconduct such as dishonesty and crime, we think there should be a focus upon behaviour which suppresses the ability of people to speak up about serious issues in the health service, whether by allowing bullying or victimisation of those who 'speak up' or blow the whistle, or by any form of harassment of individuals. There should be a focus on discouraging behaviour which runs contrary to the duty of candour, so any deliberate suppression or falsification of records or relevant information should be regarded seriously. Further, serious misconduct should include reckless mismanagement which endangers patients;
- (g) Providing that 'normal' disciplinary and performance issues are still dealt with at Trust level. Serious misconduct should first be considered at Trust level, provided the relevant director is still employed at the Trust where that misconduct is said to have occurred, but, where it occurred elsewhere, the HDSC should have power to investigate and make determinations. The HDSC should be able to receive referred complaints from organisations and individuals but, in the case of complaints by individuals, there must be a sift so that before a complaint goes forward it must have a reasonable prospect of demonstrating serious misconduct. There should be a time bar in relation to 'historic' misconduct;

⁶ See appendix 2

A REVIEW OF THE FIT AND PROPER PERSON TEST

- (h) Amending the appointment rules for commissioners of health services and appropriate ALBs⁷ so that they are prevented from appointing somebody who has been disbarred as a director.
 - (i) Aligning the test of serious misconduct to be considered by the HDSC with the same definition of misconduct under the Fit and Proper Person Regulations;
 - (j) Amending the Fit and Proper Person Test to remove the reference to directors 'being privy to' mismanagement which we do not think promotes clarity.
- 1.9 Although we have made an attempt both to define what we think should amount to 'serious misconduct' and also setting out some of what we believe the core competencies should be, we have recommended that others with a better understanding of the issues involved should complete that task.
- 1.10 Each of our recommendations has been designed to improve and make real the application of the FPPT as we believe it was originally intended to work and our recommendations have all been based upon the evidence we have heard.
- 1.11 On the evidence currently available to us, we have not at this stage recommended that the HDSC becomes a full 'regulator of directors', accrediting training, registering and regulating directors, and operating a form of revalidation process. But we do recommend that the design of the HDSC allows for a more extensive remit should that prove necessary.
- 1.12 Finally, we have not attempted to confront the same issues, in relation to the test as it applies outside the provision of health services such as in the separate area of the provision of social care. The field of work is too huge, the task too complex, to be dealt with in this short review and we have recommended that separate consideration be given to that area in due course.

TOM KARK QC & JANE RUSSELL
November 2018

⁷ See appendix 2

2. The regulations, the problems and relevant issues

The Health and Social Care Act 2008 (Regulated Activities) Regulations

- 2.1 Consideration of the Fit and Proper Person requirement was part of a wider consultation on reforming the CQC and introducing fundamental standards and the duty of candour in February 2014 following the Mid Staffordshire and Winterbourne View reports.
- 2.2 Following those inquiry reports, consideration was given to introducing a register of directors/senior leaders, which could be used to track those not meeting the expected standards. This option, which would have produced a proactive barring scheme, along the lines of the Teaching Regulation Agency (TRA) scheme, was thought to be too bureaucratic.
- 2.3 The [response to the CQC consultation and draft regulations](#) was published in July 2014. Consultation responses included:
- (a) The majority of respondents broadly agreed with the draft regulations.
 - (b) Over 78% of all responses thought that the regulations reflected the policy aims.
 - (c) There were some concerns that whilst the regulations provide a mechanism for removing unfit directors it was unclear to what extent this will contribute to the delivery of safe services and reduce the risks of poor-quality care.
 - (d) Respondents expressed concerns that the draft regulation on misconduct and mismanagement was too broad and open to interpretation. Respondents were concerned that whilst misconduct was well understood in the context of professional regulation, mismanagement was open to interpretation.
- 2.4 In 2014, the Government introduced a requirement, via Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014⁸ (the 2014 Regulations), on all health and adult social care providers registered with CQC to make sure Board directors, Board members and individuals who perform the

⁸ The regulations collectively are referred to as the 2014 Regulations.

functions equivalent to the functions of a Board director and member, were 'fit and proper' for their roles.

- 2.5 The current scheme under the 2014 Regulations, which clearly did not set up a barring scheme, was nevertheless thought to be a model for addressing the concerns raised in the Winterbourne View and Mid Staffordshire Inquiry for the following reasons:
- (a) The FPPT would be proactively used by Trusts in assessing directors, rather than passively waiting for referrals;
 - (b) Each time a new organisation registered, or a provider appointed a new director, Chairs would need to give a positive affirmation to the CQC that their directors were fit and proper (at least as far as is set out in the regulations), having assessed their previous employment history and the CQC could then check their own records to assess suitability;
 - (c) In addition, the CQC's inspection regime was thought to offer an active surveillance mechanism to assess the suitability of directors; and
 - (d) Where directors were found to be unfit, the CQC could refuse registration or, where the provider was already registered, place a condition on the provider insisting on the removal of the unfit director (like the TRA scheme, this would be in the more severe cases, i.e. where the conduct could be expected to warrant dismissal).
- 2.6 The FPPT applied to NHS providers from 27 November 2014 and for all other providers including all independent providers from April 2015 (Reg 5 (1)).
- 2.7 The scheme is that providers must ensure that its directors are not barred by the disclosure and barring service, are not undischarged bankrupts, are of good character, and have the necessary qualifications, skills and experience to undertake their role. They also must ensure that directors have not 'been responsible for' or 'involved in' or 'privy to' any serious misconduct or mismanagement in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity. How these provisions are interpreted we will consider in due course. We hope it is helpful to examine each provision and consider how these were intended to work in practice.

Who is covered?

- 2.8 Regulation 5, **Subparagraph (1)**, makes it clear that the test only applies to “Service Providers” and not to commissioners of services, regulators or educators nor other ALBs.
- 2.9 We will address this later in the report but at present this means that the test does not apply to commissioners or indeed to ALBs which do not supply services directly to users but are nevertheless integral to the wider healthcare system. The fact that the test does not apply to bodies such as Clinical Commissioning Groups (CCGs) or to NHS Improvement, or Health Education England has meant hereto that managers found to have ‘failed’ the test, or to have ‘failed’ in their function as directors, can more easily be shifted around the system and given jobs in non-providers.
- 2.10 It was the universal view of our Information Providers (IPs) that the test should be applied to all areas of the NHS including commissioners and relevant ALBs and we make that recommendation, although because of the current lack of an appropriate regulator of non-providers, we recommend as a first step that the test is extended by means of voluntary adoption.
- 2.11 **Subparagraph (2)** provides –
- (2) Unless the individual satisfies all the requirements set out in paragraph (3) [a service provider] must not appoint or have in place an individual--
 - (a) as a director of the service provider, or
 - (b) performing the functions of, or functions equivalent or similar to the functions of ... a director.
- 2.12 Part of the effect of **Subparagraph 2 (b)** is, that although everyone on the Board of Directors will be caught by the test, it is left in the hands of each Trust who else they regard as being required to meet the test. This raises its own problems.
- 2.13 **Subparagraph 2(b)** may lead to a lack of transparency and can cause unfairness if the Trust decides to use the FPPT to remove someone on the grounds that they are not a Fit and Proper Person (FPP) despite not being a Board director. Although it seems unlikely to be a common issue, we heard stories of this test being used as a vehicle for Trusts to have another bite of the disciplinary cherry by using the FPP test as an add-on measure to remove individuals on the ground that they were not FPP compliant, after disciplinary proceedings had been concluded

with only a warning or suspension. The National Officer of 'Managers in Partnership' Corrado Valle told us:

“The purpose of the regulations was to shield the public but in reality it has been turned into a sword against managers. It is used where every other means of dismissing someone have failed. The employer uses FPPR as a last resort dismissal.”

- 2.14 For many reasons it seemed to us that there should be absolute clarity as to who is regarded as covered by the test and who is not so as to remove any doubt. To this end we will recommend that Trusts should be required to declare who, apart from Board members, they regard as directors for the purposes of Regulation 5.
- 2.15 **Subparagraph (3)** sets out separate criteria some of which automatically make an individual unfit (**subparagraph (3)(e)**) i.e. those listed in schedule 4) – including being an undischarged bankrupt or being barred from working with children or vulnerable adults as a result of being on the disclosure and barring service list. Other criteria set out in **3 (a) to (d)** import a subjective element which we will examine below.

Good character

- 2.16 **Subparagraph (3)(a)** – the requirements referred to in paragraph (2) are that:
- (a) the individual is of good character
- 2.17 **Subparagraph (4)** provides that in assessing 'good character' the provider must consider the matters set out in Part 2 of Schedule 4 which, in turn, requires the provider to consider the issue of whether a person has been convicted of any offence or has been erased from the medical register or struck off any professional health register.
- 2.18 The effect of the two provisions taken together mean that, where an individual does have a conviction or convictions, or has been erased or struck off, an employer would have to consider how serious the misconduct was and must take it into account, but that exercise would not necessarily prevent the individual from taking the directorial position. Given that all regulators apply the same or a similar test of proof of 'serious professional misconduct' before erasure or striking off could take place, it seems unlikely that a person found proved to have misconducted themselves in such a way could nevertheless be a fit and proper person under the FPPT but the provision allows for rehabilitation and the passage of time which may be important considerations.

- 2.19 We will make recommendations as to the criteria for serious misconduct and the consequences of such a finding. (Please see [Chapter 9](#), A power to disqualify).

Qualifications competence, skills and experience

- 2.20 **Subparagraph 3 (b)** is considerably more complex and requires that:

(b) the individual has the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which they are employed

- 2.21 **Subparagraph (3) (b)** raises one of the knottier issues produced by these regulations, that is the assessment of qualifications and competence in a field where there are no set criteria or standards. This is exacerbated when there may be a lack of a clear history of employment, a lack of any formal qualifications and no clear criteria as to what is required for any particular role on the Trust Board. What are the qualifications required of a NED who acts as a clinical NED lead as opposed to a NED with a focus upon finance? How does the qualification to sit as a NED compare against the qualification required to act as a Chief Operating Officer (COO), Chief Financial Officer (CFO) or Director of Nursing (DN)? What happens when the role changes or the issues confronting the Board change, or a critical director leaves?
- 2.22 The issues confronting a Trust, although they may be nationally fairly typical, may nevertheless be new to that Trust. Does the CEO still have the qualifications, skills, competence and experience for the work of leading that Trust? Unless there is frequent self-evaluation and the receipt of regular support and learning to improve skills and knowledge, the competent and qualified director in year 1 may be less so in year 3.
- 2.23 Furthermore, the test of 'qualification and competence', unlike whether a person is a bankrupt or barred from working with children which are clear 'red line' tests, is much more fluid. The particular difficulty is the subjectivity of the test which may be influenced in reality by how badly a Trust needs to find a new chief executive or director of any type. In terms of the NEDs to be appointed this is likely to be an even more moveable feast because very often a NED will have a less well-defined responsibility upon the Board and will more often come from industries outside the health service.
- 2.24 In our view there needs to be a set of basic competencies designed to ensure that all those who sit on a Board have a broad understanding of what a good Board looks like, how a Board works, the individual functions on a Board and a wider understanding of the service which they are managing as directors. The brilliant finance director who has come from outside the health sector still needs to

understand the different duties which apply when governing a health system. Similarly, the brilliant doctor, when he or she steps up to the post of medical director, needs to have some understanding of financial and Board governance.

- 2.25 We will make recommendations that the core competencies to be considered when assessing whether a director meets Regulation 5 (3) (b), are better defined and are incorporated into legislation as high-level competencies, the specifics of which should be made clear by guidance. (Please see [Chapter 6](#) – Management Qualifications and Training). This is to allow for a degree of flexibility and alteration when required.
- 2.26 We have considered carefully whether to make those competencies a ‘formal gateway’ through which all must pass before becoming ‘accredited’ as Board directors, but such a gateway would require management and a considerable new regulatory structure. There is also the danger that in doing so, the responsibility of the Boards of Trusts to ensure they appoint qualified and competent people compliant with Regulation 5 might be weakened.
- 2.27 Where someone is not able fully to meet the required competencies there should be (and is) training available and we have addressed these issues elsewhere in [Chapter 6](#) - Management Qualifications and Training.

Reasonable adjustments for health

- 2.28 **Subparagraph 3 (c)** requires that the individual is capable, by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed. The purpose of this section is to comply with the Equality Act 2010 by making a reasonable accommodation for those individuals who have a disability.

Responsible for, facilitated, or privy to serious misconduct or mismanagement

- 2.29 **Subparagraph 3 (d)** also throws up its own problems. It provides as follows:

the individual has not been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity.

- 2.30 To 'be privy to' something means in ordinary English to know of something of which others are not aware. Anyone on a Board is privy to the issues raised before the Board or which come to light and are revealed to the Board. This regulation therefore would apply to the most junior member of a Board which ten years ago was responsible for 'serious mismanagement'. No-one therefore may ever be appointed to any Board who has ever, in their career, been 'privy to' serious mismanagement (which is an undefined term) or misconduct.
- 2.31 This does not seem to allow for insight, reparation, reskilling, rehabilitation, remorse or understanding. It also appears to be inconsistent with **subparagraph 4** in relation to doctors and nurses who, if they have been 'erased' or 'struck off' have undoubtedly been responsible for serious misconduct (otherwise they could not have been found to be unfit to practise) but would not be automatically excluded by reason of failing **3 (a)**. No-one to whom we spoke, including whistleblowers and patient representatives took such a draconian line as this. We doubt it was intended to have the effect which it appears it could have.
- 2.32 It is our view that the words 'privy to' are of very limited assistance. Not a single IP we spoke to was able to give a clear explanation of their understanding of those words in practice. If the words mean that the individual has been aware of serious mismanagement but failed to speak up when they should have done, the wording does not make that clear. In any event, if the individual sits on a unitary Board and allows decisions to be made which amount to serious mismanagement s/he would have facilitated that decision. We will recommend the words are removed.
- 2.33 In order to give effect to our recommendations in relation to a barring service ([see Chapter 9](#)), the term 'serious misconduct' requires better clarification and we have made recommendations to that effect. A new schedule listing issues which are capable of amounting to serious misconduct should be added to the regulations and we have made that recommendation.

Bankrupts and the DBS listed

- 2.34 **Subparagraph 3 (e)** provides that a person may not be a director unless none of the grounds of unfitness specified in Part 1 of Schedule 4 apply to the individual. Part 1 of Schedule 4 refers to those who are undischarged bankrupts or under bankruptcy or other credit restrictions and those who are on the disclosure and barring services list for vulnerable adults and children. We will recommend adding to this list anyone who is disbarred or suspended from acting as a director by the new Health Directors' Standards Council ([see Chapter 9](#)).
- 2.35 The directors of all Trusts, whether non-executive or executive directors are nowadays encouraged to 'walk the wards'. Being a director of a Trust would very

likely provide access to most areas of the hospital including the wards. It is obvious to us that there should be no distinction between clinical and non-clinical directors and that all should have a DBS check and this should currently be happening under the current regulations.

Information to be available to the CQC

2.36 **Subparagraph (5)** provides that certain information must be available to be supplied to the Care Quality Commission (CQC) in relation to everyone who holds an office or position referred to in **paragraph (2)(a) or (b)**. **Subparagraph (a)** refers to the information specified in Schedule 3. Schedule 3 provides a long list of information which the Trust is meant to hold in relation to each individual director and which includes:

- Proof of identity and a recent photograph
- A copy of a criminal record certificate issued under S.113A of the Police Act 1997 and provision of barring information under S.30A(3) of the Safeguarding Vulnerable Groups Act 2006
- A copy of an enhanced criminal record certificate issued under S.113B of the Police Act 1997 and suitability information relating to children or vulnerable adults
- Satisfactory evidence of conduct in any previous role involving health or social care, children or vulnerable adults;
- The reason why any employment involving work with children or vulnerable adults ended;
- Satisfactory documentary evidence of any qualification the individual holds relevant to the duties for which the person is employed;
- A full employment history together with a satisfactory explanation of any gaps in employment;
- Information about health.

2.37 Interestingly **paragraph 9(b)** of Schedule 3 provides that the term ‘satisfactory’, which appear in **(6)** and **(7)** above, mean ‘satisfactory’ according to the commission. So, at the time of employment, that which seemed satisfactory to the Trust, might subsequently be declared to be unsatisfactory by the CQC.

2.38 These provisions as to the information required to be held seem still to contain certain gaps. A full employment history might simply record the dates of employment but if there is no requirement for a full and proper reference, knowing where someone was employed may be of limited value.

2.39 The CQC experience (see below) has been that the quality of record keeping varies very considerably and although this is a statutory requirement some Trusts

hold little background information on directors; this is particularly so of records relating to NEDs.

2.40 We are concerned that there is no central database holding the information which Trusts are in any event expected to hold. We will recommend that a centrally held database system is created upon which information is to be held about each director ([see Chapter 8](#)). We are however very conscious of the burden upon Trusts to hold records on each of its directors. We recommend therefore that the information required to be provided is only provided to the central database holder and that the CQC should have access to that database for the purposes of its inspections where relevant. All of the information would therefore be on a single database to which both the CQC and the HDSC should have access.

2.41 We will recommend that such a database is held by NHSI.

Action to be taken where requirements in *subparagraph 3* are no longer met

2.42 **Subparagraph (6)** deals with the position where an individual no longer meets the FPPT requirement and provides that - where an individual who holds an office or position referred to in **paragraph (2)(a) or (b)** no longer meets the requirements in **paragraph (3)**, the service provider must:

(a) take such action as is necessary and proportionate to ensure that the office or position in question is held by an individual who meets such requirements, and

(b) if the individual is a health care professional, social worker or other professional registered with a health care or social care regulator, inform the regulator in question.

2.43 We suspect that this provision is perceived far more to deal with the director whose good character or misbehaviour comes into issue than whether s/he is still competent to perform the allotted function.

2.44 In relation to competency and qualification, as already indicated, we make certain recommendations as to the requirement to demonstrate basic competencies ([see Chapter 6](#)).

2.45 Separately, where a director no longer meets the FPPT as a result of serious misconduct or mismanagement, we make recommendations that the consequences of such a finding should mandate a reference to the HDSC ([see](#)

[Chapter 9](#)). Other misconduct or mismanagement should be dealt with by the Trust's normal disciplinary process alone.

Regulation 19

- 2.46 Although we have only been asked to consider the scope and application of Regulation 5, it is worth noting that Regulation 19 refers to the same test but in relation to those employed to carry out a regulated activity which, in essence, means someone directly responsible for delivering health care.
- 2.47 **Subsection 1** deals with the requirement of employed persons to be fit and proper and is similar to the equivalent requirement in Regulation 5 (3) although the Regulation 19 (1) provision is less onerous.
- (a) Regulation 19 (1)(a) to (c) mirrors Regulation 5 (3) (a) to (c) relating to good character, 'qualifications, competence, skills and experience' and health although Regulation 19 (1) does not require (and Regulation 5 (3) does), in the context of a consideration of good character, consideration of the matters set out in Part 2 of Schedule 4 (conviction and erasure).
- (b) Regulation 19 does not contain a provision relating to 'serious misconduct or mismanagement' equivalent to Regulation 5 (3) (d). Nor does it contain a provision relating to grounds of unfitness (set out in Part 1 of Schedule 4) equivalent to Regulation 5 (3) (e). Nor does it require, as referred to above, consideration of conviction and erasure in the context of good character.
- 2.48 **Subsection 2** requires that recruitment procedures be established and operated effectively to ensure that employed persons meet the requirements in Regulation 19(1).
- 2.49 **Subsection 4** deals with the retention of information and mirrors Regulation 5(5).
- 2.50 **Subsection 5** deals with the consequences of failing to meet the fit and proper requirements and mirrors Regulation 5(6).
- 2.51 **Subsection 6** states that the requirement provision (**subsection 1**) and the information retention provision (**subsection 3**) do not apply to a case in which Regulation 5 applies. In that instance, therefore, the more onerous provisions of Regulation 5 are to be applied.
- 2.52 Consideration will have to be given to ensuring that any amendments to Regulation 5 do not have the affect of misaligning the duties laid down by Regulation 19. We suggest that consideration be given to the importance of aligning the duties and requirements of the two regulations.

Recommendations in relation to the regulation itself

- 2.53 We recommend (in order to give effect to recommendation one – core competencies) that high level competencies are designed and identified and made part of the regulations. Trusts must have regard to the required competencies, the detail of which should be set out in guidance rather than statutory regulation in order to retain an element of flexibility.
- 2.54 We recommend (in order to give effect to recommendations 2 and 3 – a directors' database and mandatory references) that the Regulations be amended so as to incorporate a requirement for a mandatory reference form as part of the documentation to be retained by Trusts both in relation to past employees (written by the Trust) and current employees (written to the Trust).
- 2.55 We recommend that commissioners, relevant ALBs and other internal NHS organisations such as NHSI, adopt a voluntary code to comply with the FPPT and further undertake not to employ at director level anyone who is currently barred by the HDSC.
- 2.56 We recommend that consideration be given to ensuring that any definition of serious misconduct as it is to be applied by the HDSC is consistent with misconduct as defined in the 2014 Regulations.
- 2.57 We recommend (in order to give effect to [Rrecommendation 5](#) – the setting up of a disbarring council), that the 2014 Regulations be amended to prohibit anyone disbarred or suspended by the HDSC from being regarded as fit and proper person.
- 2.58 We recommend that, in relation to **Regulation 5 (3) (d)** of the 2014 Regulations, the words “been privy to” are removed.

3. The FPPT in previous reports

- 3.1 There have been previous reports and research which touched upon the FPPT and it would be remiss not to acknowledge them. Many of them are highly relevant to the recommendations made by us. We apologise for our lengthy recitation of those reports below but one of the features of these reviews is that they are consistently requested but their recommendations are not always fully actioned.

The Dalton Review

- 3.2 The Dalton Review published in December 2014 examined the potential for providers to meet the challenges of the future without looking outside traditional organisational boundaries, considering how their form could better support new clinical models and ways of working. It made no direct reference to the FPPT although there was relevance to the test and to our recommendations to be found in the focus upon Board Leadership and amongst the recommendations was the following:

“The Leadership Academy should support the development of the requisite skills and experience for the new operational and leadership roles and build these into the career paths and leadership and development training of current and future NHS leaders.”

The Kirkup Review

- 3.3 The [Kirkup Review](#) published in January 2018 came about as a result of the extremely poor standards of care offered in community care in Liverpool and sadly provides almost a replica of the Mid Staffordshire experience which again led to the same appalling results for patients and those receiving care. It was his report which led to the Minister’s statement announcing the current review.
- 3.4 The forward to that report is worth reprinting here in part:

“This report of a Review of widespread failings surrounding community health services based in Liverpool shows in stark terms what can happen if these services are taken for granted, and if warning signs are overlooked because of the distraction of higher-profile NHS services. A large new NHS Trust was established from scratch with an inexperienced Board and senior staff, and received inadequate scrutiny because it was regarded as low risk, in part due to the nature of the services provided. The end result was unnecessary harm to patients over a period of several years, and unnecessary stress for staff who

were, in some cases, bullied and harassed when they tried to raise concerns about deterioration in patient services. These failures were replicated in the health services the Trust provided to HM Prison Liverpool (HMP Liverpool), and contributed in part to the wider problems afflicting the prison that have received recent attention.”

- 3.5 The essence of the problems at Liverpool, in so far as they relate to management effectiveness and capability, qualifications and competence can best be summarised in the following extracted passages:

“1.2 The Trust was created as a new organisation in 2010 with a new and inexperienced management team. Their leadership was inadequate from the outset. The Chair and non-Executive Directors were also relatively inexperienced and offered insufficient challenge to the management team.

1.8 The Trust should have had clear and effective systems to manage risk, including the clinical risk arising from over-ambitious and ill-considered cost improvement measures, as well as clinical governance systems to monitor the quality of clinical services. Both should have informed the QIAs but, in practice, systems were unclear and ineffective. At one point, the Executive Director responsible for clinical quality was the Finance Director, who had set the cost improvement targets, and the Medical Director had no clear responsibility for clinical quality.

1.9 This placed significant responsibility for clinical quality on the Nurse Director, but she was, for at least part of the period, the Trust’s Chief Operating Officer, and therefore also responsible for achieving the cost improvement programme.

1.10 The result of this confused and conflicted arrangement was that Trust management neither identified properly the serious risks inherent in the cost improvement programme nor picked up the significant adverse consequences for services as they began to emerge. They remained focused predominantly on becoming a FT.

1.11 The adverse consequences were significant. First, many staff soon became demoralised. They had not felt involved in planning for the impact of staff reductions, and when they reported difficulty in maintaining safe and effective services, they did not feel listened to; certainly there was no evident change in the approach taken. Sickness absence levels rose, worsening staffing levels further.

1.12 Second, although it is clear that most staff tried hard to compensate for staff reductions, it is equally clear that services began to suffer despite their efforts. The incidence of patient harm incidents subject to mandatory reporting nationally rose, including pressure ulcers and falls. Other incidents, some serious, should also have been reported and investigated, but we heard repeated accounts that reporting was discouraged, investigation was poor, incidents were regularly downgraded in importance, and action planning for improvement was absent or invisible.

1.13 Third, it is clear to us that the reaction of the Trust Board to this gathering crisis in services was based on denial. The management team was still focused predominantly on becoming a FT, and reports of service problems were not only a distraction, they would adversely affect the assessment of the Trust's capability of achieving their goal.

1.14 The initial impact fell predominantly on the middle managers, positioned between the Trust Board's insistence on pushing through the cost reductions regardless and the staff's difficulty in maintaining safe and effective care and their consequent unhappiness. Unfortunately, faced with this undoubtedly challenging position, it is clear that their response was inadequate and inappropriate and, in too many cases, included extreme action against more junior staff, amounting to bullying. Whatever its origin in the pressure they were under themselves, this behaviour was inexcusable.

1.15 When some staff attempted to raise concerns, or in some cases grievances as a result of being bullied, the response was seriously deficient. We heard repeated accounts that staff would be suspended without being told why, or what the next steps would be.

It is clear in light of all of these failings that the Trust was seriously dysfunctional. There was a lack of leadership at senior and middle levels. The Trust Board lacked the capability to see beyond its goal of becoming a FT, and failed to recognise the significant harm that its programme of cost reduction was inflicting.”

Dr Kirkup found that external bodies responsible for assessing the effectiveness of the management also failed -

“1.21 External overview also failed to identify the service problems for at least four years. The Strategic Health Authority (SHA) regarded the Trust as low risk, despite its newness and the inexperience of its senior staff, and provided inadequate briefing when it was abolished

and the responsibility transferred to the NHS Trust Development Authority (TDA). The NHS TDA did identify concerns but subsequently reversed its assessment for reasons we were unable to determine. The Care Quality Commission (CQC) failed to identify the extent and nature of the problems until they were alerted by Rosie Cooper MP. In part, these failures were because reconfigured organisations were coming to terms with new roles and did not communicate effectively, but this is insufficient alone to account for the missed opportunity.

1.22 Any of these external organisations could have identified the problems afflicting the Trust earlier had they looked critically at the information available to them. The primary responsibility, however, lay with the organisation statutorily accountable for the service, Liverpool Community Health NHS Trust. The Trust not only failed in its duty to provide safe and effective services, it concealed this from external bodies. Both patients and staff suffered harm for too long as a result".

"5.4 An additional element of concern was strongly expressed by a number of staff. As we have set out, one of the particular features of the events at the Trust was the extent of a bullying culture among some senior Trust staff and middle managers. This was addressed by bringing in new leadership but, as is very often the case, those managers who had been the subject of complaint often moved to other posts. In the case of middle managers, these were often in nearby Trusts providing similar services. By their nature, these are the very organisations assuming responsibility for the broken-up services and their staff, raising the deeply unappealing prospect of staff whose allegations of bullying had been upheld finding themselves working once again for the managers concerned but now in a new organisation.

5.5 During the response to the 2013 CQC report, changes were initially made piecemeal. Although Mrs Page was able to bring in some new individuals to work as part of the executive team, the previous Chair, Frances Molloy, and her non-Executives were left in situ. We were consistently told, however, that there had been a strong working relationship between Frances Molloy and Bernie Cuthel, and that the decision to retain all of the Trust's non-Executive Directors until their terms of office expired created an additional layer of challenge for the interim executive Team and sent mixed

messages to Trust staff about where responsibility for the Trust's failings lay."

- 3.6 As the problems being faced by the Trust grew more serious and more urgent, why was there no recognition that the management team in place was not functioning properly and why was there so little effective challenge at Board level and was this a significant factor in the things being allowed to slide as they did? There was a serious lack of an open and candid ethos at the Trust and bullying was allowed to flourish.
- 3.7 Dr Kirkup's report highlighted several of the issues which have to be grappled with in relation to the FPPT. His review covered a period between 2010 and 2014 prior to the FPPT coming into force. In essence, had the FPPT been working properly would it or should it have made a significant difference to the management team? Would such an "inexperienced management team" have been allowed to lead the Trust? When there had apparently been mismanagement of the Trust why was part of the Board including all of the Trust's NEDs allowed to remain once the new senior management team took over? Would that now be different?
- 3.8 There appears to have been a significant lack of understanding of the various roles on the Board and a lack of training to recognise the functions required. The clear potential for conflicts of interest within the Board should have been plain to any experienced Board member or one with training in what a good Board looks like and good governance. All of that seems to have been lacking. We have tried to address these issues in our recommendations around required competencies and Board development.
- 3.9 We have also done what we can to address the issue of bullying which is seen by many staff to be endemic across the NHS and was plainly a significant issue at Liverpool. Deliberate bullying, particularly victimising those who raise concerns should in our view be regarded as 'red line' behaviour and serious misconduct.
- 3.10 The focus of Dr Kirkup's recommendation in relation to this review appears to have been to ensure that the FPPT should prevent those involved in the mismanagement at Liverpool from moving through the revolving door and taking up further senior management posts. Our terms of reference allow for a wider review than that and allow for consideration of a general improvement of the effectiveness of the test. We have tried to seize that opportunity.
- 3.11 In addition to reading his report we had the advantage of meeting Dr Kirkup. One issue which exercised both him and us was the lack of assistance he had received from the Trust concerned and, worse still, that the NEDs at the Trust had been ordered not to speak to his inquiry. Such a failure to assist a legitimate inquiry, unless there is a reasonable excuse (the circumstances of which are difficult to

imagine), seems to us to amount to serious misconduct which should be recognised as such and sanctioned. We have accordingly made a recommendation to that effect (see [Chapter 9](#) and the recommendations in relation to serious misconduct).

Lord Rose's 2014 Review of Leadership in the NHS

3.12 In 2014 Lord Rose was commissioned to undertake a review of leadership in the NHS and then a further review in relation to the ability of clinical commissioning groups to deliver the Five Year Forward View. He reported in 2015. In his Foreword he set out his focus:

“I focused my attention on acute and secondary care (both NHS Trusts and Foundation Trusts, referred to together in this document as Trusts) as well as commissioning: there is no specific coverage here of primary care. There are specific recommendations for those in leadership positions within commissioning and provider organisations but in reality many of the recommendations are for the whole of the NHS.”

3.13 He made a number of observations and recommendations which are pertinent to the issues we have now been asked to consider. Although the recommendations cited focused upon training and appraisal for managers, as will become clear in the course of this report, it is critical to address these issues if the FPPT is to be used, not simply as a barring mechanism which would on its own have a negative effect upon the system, but also to increase the quality of management by identifying required competencies and ensuring those are met by available training.

3.14 In short form the relevant recommendations were as follows:

“Training: R3: Charge Health Education England (HEE⁹) to coordinate the content, progress and quality of all NHS training including responsibility for the coordination and measurement of all management training in the NHS. At the core of this is a 90-day action cycle. HEE must promote cross-functional training in all disciplines and at all levels, coordinating the teaching of management basics such as appraisal, motivation, negotiation and leadership

R8: Require senior managers to attend accredited courses for a qualification to show that consistent levels of experience and training

⁹ This would now refer to the NHS Leadership Academy

have been reached across the NHS. On completion of this course they will enter a senior management talent pool open to all Trusts.

R9: Set, teach and embed core management competencies and associated expected behaviours at each management level.

R10: Establish a mechanism for providing on-going career support for all those in a management role allowing individuals to increasingly take charge and identify their own development needs.

R11: Establish and embed an NHS system of simple, rational appraisal (a balanced scorecard for individuals) supported by a regular course in giving and receiving appraisals as part of the core provision of the single training body. At a senior level, these appraisals should be standardised across the NHS.”

- 3.15 Although, ultimately, we have shied away from recommending a formal gateway through which all directors must pass before being considered to be capable of passing the FPPT, which would require a ‘gateway regulator’, we make several recommendations about required competencies which echo much of Lord Rose’s thinking. Although his Recommendation 3 referred to Health Education England, the appropriate body now would be the NHS Leadership Academy (NHSLA, which sits within HEE) and we have directed our recommendations to that organisation, (see [Chapter 6](#) – Managements qualifications and training).

Ed Smith’s 2015 Leadership Review

- 3.16 In 2015 Ed Smith (Deputy Chair of NHS England) was asked to conduct a review into Leadership Development in the NHS. Three of his principle recommendations relevant for our purposes were that:
- (a) There should be a system-wide focus on improvement and leadership development, including talent management, through the development of national strategies and supporting governance arrangements
 - (b) All organisations will need to develop their own strategies for improvement and leadership development (including talent management)
 - (c) Stronger alignment between the NHS Leadership Academy and Health Education England programme of activities, and a focus on system leadership
- 3.17 In recommending that core competencies be designed by NHSI and NHSLA and should be required to meet the FPPT, we hope to enhance the work already being done to improve system leadership following that report.

The University of Manchester Report 2018

- 3.18 The University of Manchester Alliance Manchester Business School [report](#) (authored by Chambers, Thorlby, Boyd et al) published, in January 2018, an extensive and comprehensive report which was the product of independent research commissioned and funded by the Department of Health Policy Research Programme¹⁰ and examined the consequences of the Francis Report and the extent to which its recommendations have been implemented across the health service. The authors carried out a survey of Trusts and received a response from 90% of all Trusts in England. The report referenced a series of previous research to which we will refer below and which accordingly need not be separately referenced here.
- 3.19 Among the report's objectives was "to uncover enablers and barriers to improving Board leadership". The report is worth examination also for its focus upon what makes a good and effective Board. Although direct consideration of the effectiveness of Boards may be outside our remit it is an important feature of the FPPT when applying the 'fit' test. The individual director is only one piece of the complex puzzle which makes up a Trust Board. The inclination is to blame the man or woman at the top of the management chain, i.e. 'the buck (and blame) stops here' approach, but the reality of any health system failure is that it is often the Board as a whole which has failed to function properly.
- 3.20 A number of issues raised in the research have relevance to how Trusts regard the FPPT, how 'Francis' has been implemented in respect of the test, as well as highlighting what is regarded as good and bad practices in Board governance. The report found:

"One significant barrier identified by a previous report to effective Board oversight of patient safety was the low level of technical competence and proficiency of Board members in measuring and assuring quality and safety, and limited training opportunities. Particularly nursing leadership was often low profile in Board deliberations and decision-making¹¹.

An observation of 24 Board meetings at eight NHS Trusts and a content analysis of Board minutes from 105 NHS Trusts, found that NEDs were variable in holding the executive team to account. Where

¹⁰ PR-R11-0914-12003 Learning from leadership changes made by Boards of hospital NHS trusts and foundation trusts following the Francis Inquiry Report June 2015-June 2017

¹¹ Page 57

NEDs were confident and tenacious, there was greater depth and discussion of all issues, including on clinical matters¹².

Some NEDs said very little in Board meetings and their ability to contribute and to hold the executive to account was very much down to individual personality and experience¹³;

Analysis of stakeholder interviews conducted by Mannion et al. (2016) also found that limited knowledge of patient safety among Board members, especially NEDs, restricted their ability to ask challenging questions about safety issues¹⁴.

In terms of behaviours, there was a worry about the cult of the CEO, cosiness of some Board committees and that some Boards were not listening to the concerns of middle managers or frontline staff and not inviting and acting on suggestions for improvement from the workforce;¹⁵

Other specific concerns included Boards having little time and resource for Board development, lack of diversity on Boards, especially Black, Asian and Minority Ethnic individuals, and also executive recruitment that fished from a very small pool, resulting in a self-perpetuating oligarchy ('the village'). This can result in it being easy for Board leaders at random to be either dropped or supported and a reluctance to look outside the system. This may be connected to the low profile of the FPP Regulation;¹⁶

Externally, poor relationships with others in the health economy were also often observed. Also, externally, there was a warning about Boards being focussed on reputation and image rather than substance and outwardly projecting an image of success whilst not having grip on operational performance;¹⁷

There was a strong emphasis on supporting and developing Board leaders: the need for coaching of individuals and teams, replacement of poor performers where needed, providing tailored and sustained support for new CEOs and development in place before people take

¹² Page 64

¹³ Endacott et al. 2013, Sheaff et al. 2015 (from University of Manchester [report](#))

¹⁴ Page 65

¹⁵ Page 68

¹⁶ Page 68

¹⁷ Page 69

up executive roles. It was important for Boards to look downwards and outwards to ensure cultural change;¹⁸

Externally, hospital chains and networks were seen as a way of drawing organisations together to learn, peer review and challenge. The incentives for Board leaders to take on poorer performing organisations had to be right.”¹⁹

3.21 The authors’ inquiries into the implementation of the FPPT revealed limited traction or effect:

“We asked Board secretaries to indicate the various potential actions their organisation had taken to implement the Fit and Proper Persons Requirement. The majority of respondents said that their organisation had carried out background checks on existing Board directors and on new appointments. A small proportion had responded to CQC concerns about directors. The other actions reported were largely concerned with requirements for directors to make an annual declaration, sometimes as part of an annual review which involved checks with relevant external agencies such as Companies House.”

3.22 The report continues:

“All respondents were asked to comment on the impacts of implementing the Fit and Proper Persons Requirement. Many said that there had been little impact, as no issues had been identified with regard to current or past directors, and the self-declaration element could be regarded as a tick box exercise. A small number of respondents suggested that the requirement had reputational benefits for the organisation and provided some reassurance to the public. It was thought that the requirement could contribute towards a culture of transparency and cause individual directors to reflect on moral and ethical values, and was not suggested to be a deterrent to recruitment.”

²⁰

3.23 In a few Trusts (it was reported):

“The requirement had prompted perceived improvements in recruitment policies, procedures and practices to provide due diligence. Views differed about the resources taken up by administering the requirement, but the overall balance was that it was not overly onerous

¹⁸ Page 70

¹⁹ Page 70

²⁰ Page 98

and was consistent with good governance, albeit that the impact might be marginal.”²¹

- 3.24 Individual respondents suggested that increasing the diversity of Board members and reducing central regulation and ‘bashing’ of managers were of greater importance with regard to recruitment to the Board:

“The checks required prior to implementing the FPP requirement were already fairly rigorous and the additional checks (insolvency, disqualified directors) were minimal in terms of the burden they represented.” [Board Secretary]

“The rationale behind Fit and Proper Persons recruitment is sound and the impacts are positive. The approach is highly relevant to ensuring rigour in the recruitment of appropriate persons to roles within the NHS.” [Chair]

“The centrally defined requirement is not that fit for purpose. It has not shown up any 'bad apples' or 'undesirables' in our Trust. Looks to be another box ticking type activity.”[NED]

- 3.25 Where the requirement had revealed potential issues, then it was reported that the impact could be large. For example, the subsequent investigation could be disruptive, time consuming and expensive. A small number of concerns were expressed about the rules emphasising problematic issues:

“One of the concerns is the retrospective nature of the requirement: actions from years ago may be picked up and gone over, as happened to a CEO in a nearby Trust. She was vindicated, but it opens up all sorts of possible needs to carry out expensive reviews (the internal review in that case was held not to be independent enough) which could cause uncertainty and instability within a Trust until the repost has been provided. I don't think the definitions are clear enough and nor are the actions that a Trust should take if it is alleged that due to some past action a Board member's fitness and properness is called into question.”²²

- 3.26 We have reflected upon this and it chimed with other evidence we heard directly. We have made recommendations to try to tackle the problem identified (see [Chapter 9](#) on sanctioning directors).

²¹ Page 98

²² Page 99

3.27 Under the heading 'Barriers to improving Board leadership':

"A number of comments highlighted the quality of current leadership as a barrier. The Board itself could be problematic, either due to poor leadership from individuals in key roles (Chair, CEO), or the culture or experience of the Board as a whole. Some respondents indicated that recruitment and retention of NEDs could also be a barrier, together with associated issues of not having appropriate skills and experience, or lack of diversity or being sufficiently representative of the local community. A small number of respondents said that insufficient remuneration of Board members was a problem, particularly in non-foundation Trusts."²³

3.28 Board development was also explored by the authors:

"We asked Board members to estimate how many days of individual leadership development they had participated in during the last 12 months. We also asked Board secretaries to estimate how many collective Board development full and half days there had been. Seminars and briefing sessions were excluded.

20% of respondents said they had not participated in any individual leadership development during the last 12 months. The median was participating in three days of leadership development.

Executive directors generally participated in more days of leadership development (median 4 days) than did NEDs and chairs (median 2 days) ($p < 0.01$, independent samples median test). This is in line with expectations, as most executive directors work full time, while NEDs are part time. To allow for this, in subsequent analyses we have applied a simple global correction factor of two to the development days indicated by NEDs and Chairs."²⁴

3.29 In the report's summary of main findings from the national survey, the authors commented:

"The Healthy NHS Board Report placed emphasis on the importance of having highly qualified directors who are capable of setting strategy, monitoring and managing performance, and emphasising quality improvement. The report also stresses that there should be a balance between continuity and renewal in appointments. Respondents found the arrival of new non-executive directors to have led to major

²³ Page 105

²⁴ Page 106

improvements in the working of the Board, including increased openness and transparency, and greater level of engagement with staff, patients and external stakeholders. These impacts were specifically linked with the introduction of non-executive directors who were challenging, mature and experienced.”²⁵

3.30 We have reflected upon Board development and training for directors in [Chapter 6](#) and made recommendations to support requirements of specific competencies before entry at director level.

3.31 The Manchester authors commented:

“The Hard Truths Report introduced the Fit and Proper Persons Test to ensure that Board members are compliant with a prescribed standard of conduct in public life and signalled the implementation of a statutory Duty of Candour, which requires providers to inform people if they believe treatment or care has caused harm. The majority of Boards said that their organisation had carried out background checks on existing Board directors and on new appointments. However, many reported that the checks had little impact and the self-declaration element could be regarded as a tick box exercise. Nevertheless, some did say that the requirement contributed towards a culture of transparency and that it was consistent with good governance.”²⁶

3.32 Under ‘Improving Governance’ the Manchester report concluded:

“We found that the Fit and Proper Persons Requirement policy has been implemented but was a low-profile policy in comparison with other initiatives. Not all Trusts are checking on continuing fitness of directors, according to Board secretaries responding to our national survey in 2016. The requirement has been interpreted rather literally. We know from events during the period of our study that there have been cases (for example at St George’s University Hospital Foundation Trust) where the policy has failed to prevent inappropriate appointments of individuals.”²⁷

3.33 The authors suggested²⁸:

“Board members need to have regular and tailored training to ensure that they know what data sources to use to notice and evaluate

²⁵ Page 113

²⁶ Page 113

²⁷ Page 164

²⁸ Page 189

problems and issues related to care quality and safety, and also those concerned with other aspects of performance such as finance, workforce and activity.

In identifying and using such data sources, Boards need to be sure that they have access to a mix of soft and hard data, that such data are quality-assured, and that there is an opportunity for regional, national, and where appropriate international benchmarking of indicators.

The Board may wish to undertake regular 360-degree appraisals of its performance – as a collective in addition to the individual appraisal that takes place for Board members – to ensure that it is sensing its own performance and impact, and is able to take steps to change and improve as necessary.

Board training and development – for both executive and non-executive members – is critically important in enabling a restless and high functioning Board, and requires sustained attention and investment, even in a tough financial climate.

The Board and its members need to be skilled in employing a wide repertoire of Board behaviours and attributes, and their training and development should focus on this at both an individual and collective level.

The Board and its members need to seek constantly to find ways of maximising their visibility, both within and beyond the organisation. The use of 360-degree Board appraisal is one way of assessing whether such visibility is happening or not.”

- 3.34 In recommending core required competencies, and the creation of a central database which will record each director’s qualifications, training and appraisals, we hope to give further force to that which was recommended by the authors of the Manchester report.

The King’s Fund Report on Leadership in the NHS 2018

- 3.35 As recently as July this year (2018) the King’s Fund published a report on leadership in the NHS. Several of the themes set out above were repeated following an extensive survey of NHS Trusts and providers in late 2017.

- (a) The survey showed that leadership vacancies are widespread, with director of operations, finance and strategy roles having particularly high vacancy rates and short tenures.
- (b) A culture of blaming individuals for failure is making leadership roles less attractive. Organisations with the most significant performance challenges experience higher levels of leadership churn. National bodies need to do more to support leaders to take on and stay in these roles.
- (c) To tackle high leadership churn, national programmes should target professional roles where concerns over the pipeline of future leaders is greatest. Regional talent management functions – largely absent since the abolition of strategic health authorities – should be rebuilt in the new joint NHS England and NHS Improvement regional teams.

3.36 The report writers commented:

“Over the past three years, several reviews of NHS leadership have attempted to better understand and address the impact of these pressures. These reviews have identified the churn of senior leadership teams – characterised by short tenures and high vacancy rates – as a particular problem...

Our interviews and roundtable event highlighted the impact leadership churn can have on organisations. Short tenures can lead to too much focus on day-to-day priorities at the expense of longer-term strategy. A ‘revolving door’ approach to leadership also undermines the credibility leaders have with staff in their own organisations and with external stakeholders. The churn of leaders can stall organisational progress, which can be especially costly as Trusts try to work collaboratively in local health and care systems to develop more integrated models of care.

Several different factors contribute to high leadership churn. These include a high level of regulatory burden and a lack of autonomy. The constant pressure to report ‘upwards’ to national bodies has left directors feeling disempowered and with less time to focus on their day-to-day jobs. Several interviewees mentioned how recent regulatory or political interventions to remove leaders for failing financial or performance targets suggested that individual leaders are sometimes held to account for system-wide problems.

Interviewees cautioned against placing too much focus on formal talent management or development programmes, as an effective talent

pipeline alone will not reduce vacancies as long as the current operating environment and treatment of leaders is unchanged.”

- 3.37 The report set out the problems faced by senior management and some of the disincentives to aspire to those roles. We have taken pains to try to avoid increasing the disincentives while recognising the need for better Board training and development.

Sir Ian Kennedy

- 3.38 Finally, it is worth noting that as long ago as 2001, Sir Ian Kennedy, in the [Bristol Royal Infirmary Report](#) into the failures in paediatric cardiac surgery between the 1980s and 1990s, made the following observation²⁹:

“For each group of healthcare professionals (doctors, nurses and midwives, the professions allied to medicine, and managers) **there should be one body charged with overseeing all aspects relating to the regulation of professional life: education, registration, training, CPD, revalidation and discipline.** The bodies should be: for doctors, the GMC; for nurses and midwives, the new Nursing and Midwifery Council; for the professions allied to medicine, the re-formed professional body for those professions; and for **senior healthcare managers, a new professional body.**”

Conclusion

- 3.39 The majority of these reports stress the need for quality management training, assessment and development. In our recommendations we have sought to underline again those critical features of the system as part of the FPPT and have made recommendations in relation to the need for required competencies to be identified.
- 3.40 We recognise that further regulation and the introduction of a barring system may have a chilling effect, which is why the constant theme of this report will be the importance of balancing any system allowing for the barring of directors guilty of serious misconduct, with training and support for all others. We also recognise that a training programme is not in any sense a cure-all, but only part of a package of measures which is required to develop and support senior management teams.
- 3.41 In considering how the current test operates and how, if at all it should be amended, we have taken the above prior reports into consideration. Where previous conclusions and recommendations are relevant to this review we have

²⁹ The Bristol Inquiry Report p.446 para 70

A REVIEW OF THE FIT AND PROPER PERSON TEST

adopted them when supported by the evidence we have heard. We would respectfully commend the reader at least to the summaries of each of the reports listed above. Many of the 'fresh ideas' in this report have been prefaced and trailed before us.

4. THE CQC AND REGULATION 5

The role of the CQC

- 4.1 The CQC is currently integral to the effective operation of the FPPT as the regulator of all health and social care providers registered in England. These providers include hospitals, care homes and general practices. The application of the FPPT in NHS Trusts and FTs is part of the CQC 'Well-Led' programme of inspections which ascertains whether each Trust is complying adequately with it in respect of each of its directors. Where there is a requirement in the regulations to supply information or to hold information about directorial appointments, the requirement is to provide them or hold them available for the CQC. Whether or not the documentation held in respect of any appointment is 'satisfactory' is only so if it is in the opinion of the CQC³⁰.
- 4.2 Although NHS Improvement (NHSI) via the Trust Development Authority (TDA) is involved in appointments for NEDs to NHS Trusts, the only regulator that considers the FPPT and inspects whether it is being properly applied by providers is the CQC³¹. Since 2014, the leadership of Trusts has been assessed by the CQC according to eight 'key lines of enquiry' on how well they are led. The 'Well-Led' domain is defined by the CQC as '(how well) the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture' (CQC 2016).
- 4.3 The CQC operates its inspectorate function so far as the FPPT as follows:
- (a) At registration the inspectors will check that the provider has ensured that their directors meet the eligibility criteria i.e. that they are not on the DBS and that they are not disqualified directors;
 - (b) Where the role requires a specific qualification the CQC will check that the director has that qualification;
 - (c) The CQC will check that recruitment policies are in line with public appointments' guidance and the Nolan principles.

³⁰ Schedule 3 para 9(b)

³¹ NHSI may also consider the application of the FPPT by providers where it is in receipt of information (for example, from whistleblowing) that is relevant to the governance of the Trust under the provider licence.

- (d) At an inspection (part of a 'Well-Led' inspection) the CQC will check that the Regulation 5 processes are being followed both by interviewing staff and checking documentary records;
- (e) Where information from a third party is received by the CQC about a director subject to the FPPT, they will convene a management review meeting and consider whether the information raises a FPP concern; if further action is required the CQC will send the information to the provider requesting a response;
- (f) Concerns raised about the Chief Executive or Chair (or indeed any executive or non-executive director) of a Trust will also be brought to the attention of NHSI³². If there is a FPPT concern in relation to a NED of an NHS Trust that may also be referred to the NHS Trust Development Authority (TDA) as the appointing authority;
- (g) Where the thresholds of FPPT are not met but concerns still highlight issues at the provider these may be dealt with under an alternative regulation such as Regulation 17 which looks at Good Governance or Regulation 19 which looks at Fit and Proper Staff.

Well-Led Inspections

4.4 In each 'Well-Led' inspection the CQC will follow key lines of inquiry:

- (a) Leadership capacity and capability: Is there the leadership capacity and capability to deliver high-quality, sustainable care?
- (b) Vision and strategy: Is there a clear vision and credible strategy to deliver high-quality sustainable care to people, and robust plans to deliver?
- (c) Culture of the organisation: Is there a culture of high-quality, sustainable care?
- (d) Governance and management: Are there clear responsibilities, roles and systems of accountability to support good governance and management?
- (e) Management of risk and performance: Are there clear and effective processes for managing risks, issues and performance?
- (f) Management of information: Is appropriate and accurate information being effectively processed, challenged and acted on?

³² There is an information sharing agreement between CQC and NHSI regarding FPPR.

(g) Engagement and involvement: Are the people who use services, the public, staff and external partners engaged and involved to support high-quality sustainable services?

(h) Learning, improvement and innovation: Are there robust systems and processes for learning, continuous improvement and innovation?

4.5 It is for providers to ensure their Board-level directors satisfy the FPPT. The CQC is able to check that providers have the processes to meet the requirements and they can do so, either after a notification³³ has been received when a new director is being appointed or during an inspection of a provider, and could, under powers contained in the Health and Social Care Act 2008, impose a condition on the provider to require the removal of an unfit director.

4.6 If a provider fails to comply with such a condition, it could lead to regulatory or enforcement action by the CQC.

The CQC consultation in 2017

4.7 The CQC published a [consultation](#), in June 2017, which contained proposals on how they should register, monitor, inspect and rate new models of care and large or complex providers; how they used their unique knowledge and capability to encourage improvements in the quality of care in local areas; how they carried out their role in relation to the Regulation 5; and how they regulate primary medical care services and adult social care services. Plainly only part of this consultation concerned the application of the FPPT.

4.8 Of the 137 respondents, 102 explicitly supported the proposed guidance for providers on interpreting what is meant in Regulation 5 by “serious mismanagement” and “serious misconduct”, with several highlighting the proposals’ potential for increased clarity and accessibility. A minority of respondents opposed the proposed guidance, with some criticising the perceived ambiguity of the language, for example questioning how one can accurately measure an individual’s performance against the term “reasonable”.

2018 CQC FPPT Guidance

4.9 Following the 2017 consultation, in January 2018, the CQC strengthened its approach and guidance regarding the FPPR for directors as part of its wider consultation into the [‘Next phase of regulation’](#)

³³ The CQC do not require NHS Trusts and FTs to notify them of a change of Board membership but they expect that this information will be shared with them.

A REVIEW OF THE FIT AND PROPER PERSON TEST

- 4.10 So far as this review is concerned we have focused upon the current guidance in relation to Regulation 5 rather than how CQC guidance may have changed historically. We will also focus on those aspects of the guidance which have most relevance to some of the more difficult issues thrown up by the 2014 Regulations.
- 4.11 Changes the CQC made in 2018 regarding the FPPT were:
- (a) Immediate transfer from the CQC to providers of all intelligence relating to the fit and proper person requirement to increase transparency, rather than CQC triaging for relevance;
 - (b) Stronger guidance on what is meant by 'serious mismanagement' and 'serious misconduct' – including for the first time explicit inclusion of bullying and harassment; and
 - (c) More effective tracking and reporting of FPPT concerns, and actions taken, to strengthen CQC's overall view of health and care provision.
- 4.12 The CQC provides guidance to providers on:
- [General overview of FPPR \(Directors\)](#)
 - [Regulation 5 \(FPPR for directors\)](#)
 - [Regulation 19 \(FPPR for all staff\)](#)³⁴
- 4.13 The following statistics have been provided by the CQC relating to the operation of the FPPR since its introduction in 2014. There have been 92 FPPR cases reviewed in the hospital sector with Trusts or NHS Foundation Trusts as well as independent hospitals and ambulances since November 2014 **following referrals to the CQC**. The outcomes were as follows:
- (a) 23 cases where the Trust has confirmed the fitness of the director(s) after an internal or external investigation;
 - (b) 20 cases where the information received did not meet the threshold of FPPR (e.g. there was not enough third party evidence to support the allegation, or the allegation was not covered by Regulation 5 as the person was not in a director's position);
 - (c) 10 cases where the Trust responded with an action plan in response to the information or concern;

³⁴ Please note that this Review is limited to Regulation 5.

- (d) 2 cases where the Trust held a disciplinary leading to the Director(s) being dismissed for gross misconduct;
- (e) 20 cases where the Director left the Trust before the conclusion of the FPPR;
- (f) 5 cases managed by NHS Protect which were allegations of fraud;
- (g) 2 cases which led to the urgent suspension of a provider (in each case this related to an ambulance Trust); and
- (h) 6 cases where the person referred was not in a director role;
- (i) 4 new cases which are ongoing and have not yet been concluded.

To whom does the Regulation apply?

4.14 The FPPT plainly applies currently only to ‘providers’ registered with the CQC and only to those on the Board and equivalents. The CQC 2018 guidance says:

“To ensure that providers comply with the regulation, they must not have an unfit director in position. Ultimately, a provider should determine which individuals fall within the scope of the regulation, and CQC will take a view on whether they have done this effectively.”

4.15 The responsibility not only for applying the test but also deciding, beyond those on the Board, **to whom it should be applied** therefore is left firmly in the hands of each Trust. This seems likely to lead to disparity between different Trusts as to whom the test is applied.

4.16 It has been suggested by some IPs that this has been used inappropriately by Trusts identifying staff who do not truly have a directorial role and applying the FPPT to them in order to bolster, or as an add-on to, disciplinary proceedings. This potential unfairness could be mitigated and greater transparency provided by applying a requirement that Trusts must identify all those whom it considers to have a directorial role and that list should be provided to the CQC or to the central database holder (or both) ([Recommendation 2](#)).

4.17 The guidance does however make it clear that the test does not apply to governors of Foundation Trusts. In this respect we have examined carefully whether or not it should be extended to governing Boards. We discovered no appetite to extend the test to Governors of Foundation Trusts. They are not in directorial positions and have no executive functions. Extending the test to such bodies would be burdensome and, we were told, pointless. We have therefore made no recommendation in this respect.

What constitutes a breach of the FPPR and how is it evidenced?

4.18 The CQC 2018 guidance then goes on to identify what would constitute a breach of the regulations and sets out the following guidance:

“The regulation is breached if a provider has in place someone who does not satisfy the FPPR. Evidence of this could be if:

- A director is unfit on a ‘mandatory’ ground, such as a relevant undischarged conviction or bankruptcy. The provider will determine this.
- A provider does not have a proper process in place to enable it to make the robust assessments required by the FPPR.
- On receipt of information about a director’s fitness, a decision is reached on the fitness of the director that is not in the range of decisions that a reasonable person would make.
- A director has been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere, which if provided in England, would be a regulated activity.”

4.19 In relation to bullet-point 2 (not having in place a proper process), this is said to be potential evidence that a director is in fact unfit. This highlights the difficulty that the CQC has as a result of its role as an inspector of the organisation. The CQC does not regulate nor can it investigate individual directors. Therefore, the CQC tends to look at the processes applied in order to reach a particular result. As it was candidly admitted to us, a Trust could have all the correct processes in place but these may not elicit all the relevant information about a director. This could result, in our view, in the appointment of a potentially unfit director which would not be picked up on a CQC review. The CQC would have limited ability to investigate the individual nor does it have the power to correct that position directly.

- 4.20 Provided therefore a Trust can demonstrate that it has done background ‘good character checks’, a DBS check³⁵, has a CV and has interviewed the individual concerned, the fact that the putative director has not in fact got sufficient experience or qualification for the role to which they are appointed is currently, in reality, unlikely to be flagged up³⁶. While we heard plenty of evidence of thorough and comprehensive checks being performed by some Trusts, as well as 360 degree appraisals being sought and techniques such as psychometric testing being adopted, we also heard evidence of poorer appointment practices, including one interview of a putative Trust executive which was just 45 minutes long following which the appointment was made.
- 4.21 The third bullet point applies similarly to the level of test applied at Judicial Review – was the appointment outside the bounds of reasonableness? Again, this reflects the CQC organisational approach and its understandable reluctance to attempt to replace the Trust’s judgment with its own, except in the most obvious of circumstances. In effect this will only come into play if the information provided about the putative director was so lacking or the information which was there ran directly contrary to appointment³⁷.
- 4.22 The fourth bullet point which relates to previous mismanagement suffers from the criticisms identified elsewhere. There is a lack of centralised information and Trusts have to rely on the information provided by the applicant. The test itself is more opaque than it should be. Given that this could be used to deprive someone of an opportunity or indeed their job, greater certainty seems to us to be required, but also it is problematic that there is no independent database or history kept with respect to those occupying senior directorial position in the NHS so that records of performance and behaviour can easily be checked. As we consider elsewhere, the quality of information held by Trusts about the backgrounds of their directors differs markedly.

Systems, processes and information retained by trusts

- 4.23 The guidance then moves on to deal with what the CQC expects to see when a provider implements the regulation:

“The provider is responsible for the appointment, management and dismissal of its directors. The provider must be able to show evidence **that appropriate systems and processes are in place** to

³⁵ Currently a DBS enhanced with barred list check is not routine for all directors. It is only available for those directors who carry out a regulated activity.

³⁶ Although it is possible in theory for this to be flagged up by the current check list that the inspectors use.

³⁷ This has not happened to date .

ensure that all new and existing directors are, and continue to be, fit and that no appointments meet any of the unfitness criteria set out in Schedule 4 of the regulations. The provider should be able to demonstrate that appointments of existing directors (and new directors) have been secured through robust and thorough appointments processes.” **(our emphasis)**

4.24 This underlines the CQC’s role which is to check that there is evidence that a provider has systems and processes in place. Specifically, the CQC is not there to second guess an appointment nor to review the qualifications, background and curriculum vitae of the appointee. This is not intended as criticism of the CQC, but it underlines the issue which is that the assurances given by the CQC via their ‘Well-Led’ rating, if based (as in part they are) upon the Trust’s application of the FPPT, may be optimistic and in this respect at least not well-founded.

4.25 The guidance makes this even clearer in the next paragraph:

“CQC recognises that a provider may not have had access to all relevant information about a director, or that a director may supply, or may have supplied, false or misleading information. In these situations, CQC will look to see that the provider has since made every reasonable effort to assure itself about an individual by all means available, and that it has addressed the issue in the light of new and additional information. This will include an assurance that the review process ensures that the provider meets Regulation 5.”

4.26 The CQC guidance then points to other guidance available to assist Trusts to ensure the recruitment process is sound. Some Chairs and Chief Executives will no doubt have regard to such guidance and may have received training in the appointment process itself. Other Chairs and Chief Executives may not.

Guidance on misconduct and mismanagement

4.27 The CQC guidance advises Trusts how to determine whether an applicant has been ‘involved in or privy to serious misconduct or mismanagement’. Again, the CQC will only look to see whether the provider has acted reasonably in making its determination on these issues, rather than looking at the information itself, or examining whether there were areas of information which should have been present but which were missing.

4.28 In relation to the assessment of whether a director has been privy to mismanagement the guidance offers this:

“In relation to being “privity to”, the provider must be assured, through its recruitment and ongoing performance management processes, that directors have not been complicit with serious misconduct or mismanagement. They should be able to demonstrate this through appropriate records and information that they hold about the individual.”

4.29 The guidance deals with issues arising during an inspection:

“For NHS bodies, as part of the inspection process we will assess and report whether the Trust has robust and thorough processes in place for the recruitment, management, discipline and dismissal of its directors.

The assessment will be made as part of the Well-Led key question at the Trust level (KLOE [Key Lines of Enquiry] W1: Is there the leadership capacity and capability to deliver high-quality, sustainable care? with the related prompt W1.1: Do leaders have the skills, knowledge, experience and integrity that they need – both when they are appointed and on an ongoing basis?).

Inspection teams should confirm whether the provider has undertaken appropriate appointments of its Board directors and has satisfied itself that at appointment, and subsequently, all directors are deemed to be of good character and are not unfit.

This may involve:

- Checking personnel files of recently appointed directors (including internal appointments of existing staff)
- Checking information or records about appraisal rates for executive and non-executive directors
- Checking that the provider is aware of the various guidelines on recruiting executives and that they have implemented procedures in line with this best practice.”

4.30 The CQC guidance³⁸ deals both with examples of misconduct and mismanagement. In terms of what might constitute past mismanagement the CQC suggests:

³⁸ Updated January 2018

A REVIEW OF THE FIT AND PROPER PERSON TEST

- Transmitting to a public authority, or any other person, inaccurate information without taking reasonably competent steps to ensure it was correct.
- Failing to interpret data in an appropriate way.
- Suppressing reports where the findings may be compromising for the organisation.
- Failing to have an effective system in place to protect staff who have raised concerns.
- Failing to learn from incidents, complaints and when things go wrong.
- Failing to model and promote standards of behaviour expected of those in public life, including protecting personal reputation, or the interests of another individual, over the interests of people who use a service, staff or the public.
- Failing to implement quality, safety and/or process improvements in a timely way, where there are recommendations or where the need is obvious.

4.31 The guidance continues:

“Not all misconduct or mismanagement in which a director has had some involvement will reach the threshold of “serious”. Where there is evidence of misconduct or mismanagement that is not judged to be “serious”, the provisions of **Regulation 5(3)(d)** do not apply. However, it will be for the provider (as the employer) to determine the most appropriate response, in order to ensure that performance is managed and the quality and safety of services is assured.”

4.32 What is regarded by the CQC as below the line of serious misconduct or mismanagement is:

- Intermittent poor attendance
- Minor breaches of security
- Minor misuse of employer’s assets

- Failure to follow agreed policies where such failure has limited repercussions

4.33 What is suggested to be above the line:

- Fraud or theft
- Criminal offence save minor motoring
- Assault
- Sexual harassment (of staff)
- Bullying
- Victimisation of staff who raise legitimate concerns
- Dishonesty e.g. false references, misleading info on a CV
- Disregard for appropriate standards of governance
- Failure to make full and timely reports of significant issues
- Repeated tolerance of poor practice
- Failure to develop and manage business, financial or clinical plans

4.34 Some behaviour, such as deliberately suppressing reports which might be compromising, seems to be so inconsistent with what the public would expect of a senior director that such behaviour, if proved, might well be regarded as sufficient to lead to a bar on any future employment at a senior level in the NHS. There is however currently no such capability. At present, as the CQC makes clear, the decision as to whether certain behaviour amounts to serious misconduct or mismanagement is to be decided by the Trust concerned. Although a Trust may take disciplinary measures against a director who acts in such a way, the severest sanction is currently dismissal from that Trust. There is nothing to prevent the director moving to another job within the service.

4.35 It is this central issue which causes concern to a number of those we spoke to. Furthermore, the good Trust will act appropriately, the poorly governed Trust may

not. The CQC's inspection³⁹ may or may not pick out a poor process and if it does the Trust is likely simply to receive a 'Requires Improvement' or an 'Inadequate' rating depending on how the Trust fares in respect of the other aspects of the 'Well-Led' inspection.

4.36 We commend the reader to the CQC guidance in its totality and we hope not to have done it disservice by not duplicating all of it here. The guidance helpfully goes on to deal with the terms 'responsible for' 'contributed to' and 'facilitated'.

4.37 Dealing with the question of historical mismanagement the guidance advises:

"The relevant matters can arise either in the director's current role, in a former role within the provider's organisation, when the director carried out any role where he or she was concerned with a service that is regulated by CQC or which, if provided outside the UK, would be a regulated activity if the activity was carried out within the UK."

4.38 It is clear that the mismanagement may have occurred at any time in the director's career and at any registered provider. This in itself can give rise to problems and allows complaints to be made about a director's historical conduct at a different provider organisation. This has caused significant difficulties for Trusts trying to investigate bad behaviour in previous employments. We address this issue further in [Chapter 9](#) and in our recommendations.

Action the CQC can take

4.39 Although the 2014 Regulations provided for a set of fundamental standards relating to issues such as: consent, safeguarding from abuse, meeting nutritional and hydration needs, good governance and the provision of information to the CQC, the breach of which could lead to criminal sanction, meeting the requirements of the Fit and Proper Person test was not included as a fundamental standard.

4.40 The CQC sets out in its guidance the action it is able to take when it discovers a breach:

"When a provider is unable to demonstrate that it has undertaken the appropriate checks when appointing directors, whether externally or through internal promotion, this may potentially indicate a breach of the regulation. We will use our enforcement policy and decision tree

³⁹ To be clear, the CQC 'Well Led' rating is not driven by FPPR in isolation and depends upon the eight key lines of enquiry set out above.

to decide whether there is a breach of the regulation and, if so, what regulatory action to take.

In the case of a new aspirant registrant, we may refuse the registration if the provider is unable to satisfy us that it has made appropriate checks in line with best practice.

Although individual directors may be fit for their roles, collectively, the Board may demonstrate a lack of fitness. In this case, we would address the matter as a governance issue or, in the most serious cases, through special measures. In all situations, we will need to determine the most appropriate, relevant and proportionate approach in meeting this regulation on a case-by-case basis.”

- 4.41 The high point of the powers used by the CQC with respect to NHS Trusts is to recommend that a Trust is put into Special Measures. This recommendation would then go to NHSI and acceptance of such a recommendation leads to a programme of intensive support.

Meeting the CQC

- 4.42 We had a number of opportunities of speaking with the CQC and our request to attend a ‘Well-Led’ inspection was granted.
- 4.43 In meeting the senior management of the CQC the following views, truths and issues emerged:
- (a) All ‘Well-Led’ inspections are announced inspections – this should mean therefore that the Trust concerned has the opportunity of ensuring its house is in order. It follows that if a Trust ‘fails’⁴⁰ the inspection in the sense of receiving a rating of Requires Improvement or Inadequate, insufficient focus is likely to have been applied to the records or preparation of interviews which need to be kept and produced to the CQC.
 - (b) With regard to a ‘Well-Led’ inspection the information held by each Trust with regard to the directors on its Board should be comprehensive and very easily accessible. With modern data collection systems, there should be no reason why the majority of the information could not be transferred and inspected electronically although we recognise that this only relates to that part of the inspection which focuses upon the records retained and that interviews are an important part of any such inspection.

⁴⁰ We understand that it is not a ‘pass’ or ‘fail’ test but use this term for ease of expression.

- (c) Although the CQC will look at how the executive and non-executive team come together as a Board, the way this is done is to look at the outputs/outcomes (i.e. care quality indicators) of the hospital. The CQC will speak to clinical staff (including medical, nursing and allied health professionals) and focus groups. In one Trust where there had been a large number of whistleblowers the Trust was found to be inadequate on 'Well-Led' and was put into Special Measures. This in one sense is perfectly sensible, what matters ultimately is how well patients are cared for and poor care is a reflection upon the management of the Trust. However, the care delivered is a measure but not the arbiter of whether a Trust is well led; a Trust may deliver a good service because of the good management of the Board and the medical team, or because there is a good medical team in spite of the Board.
- (d) The CQC will not look at a particular director and track his or her career backwards to see where and how they have performed previously, although there may be some 'soft' knowledge around this issue. The CQC does not regard its role as being to check the background of each director; that is the function of the Board. The CQC's job is to check that proper systems and processes are in place rather than make specific checks against the list of directors. The responsibility for applying the FPPT is that of the Trust and not the CQC.
- (e) If a Trust is assessed as 'Inadequate' in 'Well-Led' and one other domain (safe, caring, effective or responsive), the outcome would be a recommendation that the Trust is put into Special Measures.
- (f) There was support for a centralised information system. Currently, there is no central list of directors and Board members, there is no test of competency, there is no centrally-held history and the CQC does not in general terms hold personal information about the historical successes or failures of directors in the system;
- (g) The CQC is not opposed to a register of directors (but would not be the appropriate organisation to hold it) and would welcome the implementation of high-level criteria to assist the assessment of individuals; those criteria should include honesty, integrity, competence and capability, and financial soundness.

4.44 We also had a meeting with the Chief Inspector of Hospitals, Professor Ted Baker. He was keen to underline the importance of incentivising people and giving status to the role of director. If the response to this review were all about identifying failure, then in his view, that would amount to another disincentive to aspire to the role of director. We very much took those views on board and are well aware that the job of executive director on the Board of any Trust is a challenging one which

we should be careful not to make less attractive than it is presently. This was also reflected in the views of Baroness Harding and Ian Dalton from NHSI, and Mr Harry Cayton CBE (then Chief Executive of the Professional Standards Authority (PSA) and Sir Bruce Keogh, (Chair of Birmingham Women's and Children's FT) all of whose experience and wisdom in this field we would be foolish to ignore.

Joining an Inspection

- 4.45 We had the opportunity of attending a 'Well-Led' inspection over the course of two days. This fly on the wall experience was instructive and we are grateful to the CQC and the Trust concerned for allowing us to attend and observe. The attendance was revealing and helpful to see at first-hand how things actually worked. It underlined many of the points already made, in particular that the inspection is in essence a systems-led review. The inspection regime does not explore the quality of management, other than by the health outcomes of the Trust, but, so far as the FPPT is concerned, examines documentation and speaks to relevant participants in the Trust about the appointment process and the issue of continuous training (relevant to the question of continuing competence and qualification).
- 4.46 Prior to the inspection the CQC would be furnished with the Board Minutes of the Trust, information on personnel files of Executive Directors and NEDs, the Corporate Risk Register, the Board Assurance Framework, information about any changes in leadership and Trust policies. During the inspection the inspectors would interview all of the executive directors and some of the NEDs. They would always interview the NED with responsibility for clinical governance. They would also look at the personnel files of the directors.
- 4.47 Although we were assisted by being furnished with documents such as the key lines of inquiry on a 'Well-Led' inspection, witnessing part of the inspection itself provided a fuller flavour. The following themes emerged:

Information

- (a) There was a degree of information-sharing within the system already.
- (b) If the CQC received adverse information about a director it could convene a management review meeting to determine whether the information indicates a possible Regulation 5 concern; the CQC would inform the director and the provider (but would not reveal the identity of the informant) and would expect the provider to respond within 10 days. The provider would then need to assure the CQC that it had followed a robust process to identify whether the person is FPPT compliant;

- (c) Directors' histories could be shared by the CQC with the employing Trust and the CQC could suggest that a Trust undertakes a risk assessment about a particular director;
- (d) If new information about a director became apparent, the CQC would share that information with the employing Trust;
- (e) If there were concerns about a director's conduct with a previous provider the (new) Trust would need to make sufficient attempts to obtain relevant information and establish the primary facts as clearly as possible;
- (f) Under the current system, information retention is sometimes incomplete;
- (g) Although NHSI has a generic job description for NEDs there is none for executive positions. A job description is not always available in the files;
- (h) The CQC does not see the content of any previous settlement agreements in relation to any current director, nor does it see the settlement agreements of past directors who have moved on. It does not always see each director's appraisal, and 360 degree appraisals are not always available. There is sometimes incomplete information potentially relevant to FPPT such as whistleblower reports and grievance complaints.
- (i) The CQC will look at outcomes such as incidents and complaints; it does not look specifically at the qualifications or training for Board Directors;

Speaking up

- 4.48 The Trust's 'Speaking Up Guardian' (SUG) under the Freedom to Speak Up (FTSU) regime was one of 30 national network trainers. About 260 people had 'spoken up' since November 2016, or about 15 per month. If there is a patient safety issue involved, then that is escalated immediately. The SUG attended the Board twice a year and one of the NEDs had the lead for FTSU.
- 4.49 A phrase we heard repeated by some inspectors at the inspection was 'there's a lot of reassurance, without assurance' which we interpreted as meaning there was comfort being given, without the solid evidential foundation to support it. From others we heard different perspectives in relation to the management review process.
- 4.50 We heard from one Chairman of a large Trust who had been involved in such a process, who told us:
- "We had a referral about our X director. There was believed to have been an inappropriate payment that had been made at the previous

Trust. CQC told us they would put it in front of a panel. They were vague about what the panel did. Our impression was that they would do the FPP investigation and we would have to go to the panel at some point. We were confused about the process and our role within it. The CQC then said it was our duty to do the investigation. ... we said it was difficult because it was at a previous employer but they still said it was our duty.”

- 4.51 The CQC take issue with this description of their process and wanted us to make it clear that this description does not match the full content of their communication with the Trust concerned and pointed towards published guidance which they say make clear the duties and expectations of those responsible for ensuring that the requirements of the FPPT are met. It is not for us to decide where the reality lies, but this was clearly the Chairman’s honestly held view. Perhaps more importantly, this vignette is illustrative of the various problems Trusts face investigating misconduct at previous employers and of a degree of confusion about the system the CQC operates. Although the Trust eventually employed an independent investigator to look into the matter, any such investigation would inevitably be hampered by the Trust’s lack of powers to require information as opposed to relying upon cooperation.
- 4.52 In another similar case, the individual concerned resigned just as the disciplinary process started so the Trust had no locus over his case or future. The process continued but no action could be taken because the director had resigned. The individual also made allegations against the CEO. In those circumstances it was explained “you can quite quickly run out of people who do not have to recuse themselves” from being involved in an independent investigation.
- 4.53 One of our IP’s, a whistleblower, told us that he had complained to the CQC about something which had happened to him many years previously. He had provided the CQC with information. He then started getting letters and emails from lawyers at the Trust concerned. The Trust then employed two barristers to undertake the investigation but they had not been provided with any information that he had provided to the CQC. He told us: “I was cross examined for two days, it felt like the tables had been turned”. He was frustrated that none of the information provided to the CQC had found its way to the Trust. He did not regard the Trust’s investigation as truly independent.
- 4.54 Whether his perception of the investigation not being independent was accurate or not, that was clearly his honest perception. Rightly or wrongly he felt let down by the CQC. He described his view, which was reflected in the comments made by other whistleblowers whom we met as:

“In my view, the FPPR in the hands of the CQC is a monumental failure. Whether that is because the legislation is poorly framed or the CQC has failed in its administration is a good question”

4.55 Another told us:

“In conclusion it appears to me that whatever the weaknesses of the statute, a major problem with FPPR has been the partisan way in which CQC administers it when it comes to whistleblower suppression. Directors who, as Sir Robert Francis has advised, are responsible for whistleblower suppression should forfeit their jobs. Instead they prosper, moving on to other posts. The whistleblowers on the other hand are ruined. That is my own experience and CQC has neglected the responsibility given to it by Parliament to address this. This all sets a terrible example disempowering staff and discouraging them from raising legitimate concerns.”

4.56 Those views although of course subjective, were not in any way unique. The unsatisfactory nature of the process described above, whether exacerbated by the nature and limitations of the test itself or not, is perhaps obvious and the dissatisfaction is undoubtedly real and genuinely felt. If these sentiments were without proper grounds, we could ignore them, but the reality is that there is no organisation properly equipped at present to undertake an independent investigation of serious complaints under the FPPT and even where there has been a Trust investigation and a finding of serious misconduct there will be no disbarment of that director by the CQC. There is still nothing to prevent that individual moving on to another part of the NHS system.

Conclusions and recommendations in relation to the CQC

4.57 The CQC has an important function to undertake but it is not a regulator of directors and cannot meet the expectation which was raised in relation to barring poor directors who fail the FPPT. We make a number of recommendations which will affect the CQC operation of its functions on ‘Well-Led’ inspections.

4.58 We recommend that whether a director has the qualifications, competence, skills and experience should be assessed against specific criteria to be designed by NHSI and others ([Recommendation 1](#)).

4.59 We recommend that a centralised information system is set up ([Recommendation 2](#)), to which the CQC will have access, which would retain information about each director and their qualifications, background, complaints and grievances. We recommend that, in the first instance and until legislation is passed, the CQC should amend its Guidance to include a recommendation that all Trusts should

A REVIEW OF THE FIT AND PROPER PERSON TEST

submit the relevant information to the Central Database Holder. Whether or not Trusts do so will be reviewed at the CQC's 'Well-Led' reviews. We recommend that the submission of information is put on a firm statutory footing in due course.

- 4.60 The CQC should have access to and should examine the information database to ensure that Trusts have applied those criteria in appointments, in training and development in relation to its directors, as part of the CQC 'Well-Led' inspections.
- 4.61 We recommend that part of the information to be centrally held will include full mandatory references ([Recommendation 3](#)) and that the CQC should have the power to inspect these both in relation to the new employing Trust but also in relation to the Trust which wrote the reference. Whether or not the old Trust complied with the mandatory reference scheme should form part of the CQC 'Well-Led' inspection.
- 4.62 We recommend ([Recommendation 5](#)) that a system is set up to allow the barring of directors found to have committed acts of serious misconduct but we do not think that the CQC is the right organisation to hold such powers. However, the CQC should have the right of referral of complaints about directors to the organisation performing that role.
- 4.63 The CQC and HDSC ([see Chapter 9](#)) should be able to exchange information freely.

5. NHS Improvement

Overview

- 5.1 NHS Improvement (NHSI) oversees NHS Trusts, NHS Foundation Trusts and independent providers which provide NHS funded care. We were told that almost all independent providers do provide some NHS funded care⁴¹. Part of NHSI's job is to support Trusts to improve the quality of the care they deliver, their efficiency and their financial management⁴².
- 5.2 NHSI is the operational name for the organisation, launched on 1 April 2016, that brought together various different bodies including Monitor and the NHS Trust Development Authority (TDA). NHSI is a combination of the continuing statutory functions vested separately in Monitor and the TDA which, collectively, can be described as a general improvement power. NHSI therefore has the power of intervention where services are not up to standard. NHSI (Monitor) has the power to require a number of bodies (including all providers and CCGs) to provide it with any information, documents, records or other items which it considers necessary or expedient to have for the purposes of any of its regulatory functions⁴³. NHS TDA has the power to **request** information from English NHS Trusts which it requires to carry out its functions⁴⁴.
- 5.3 NHSI has a role in the appointment of directors to NHS Trusts but not in relation to Foundation Trusts (FTs)⁴⁵. NHSI will therefore sit on appointment panels for Trusts. The NHSI has the power of intervention in relation to FTs and the ability to require the removal of directors but not in relation to NHS Trusts⁴⁶. However, despite these differences in the powers held by NHSI for the purposes of this review we were not encouraged to make any distinction between FTs and other Trusts.

⁴¹ Since April 2014, independent providers of health care services for the purposes of the NHS need an NHS Provider Licence unless they are exempt (Part 1, Chapter 3 of the Health and Social Care Act 2012). One of the exemptions is for small providers whose annual turnover from NHS services is less than £10 million. To be granted a licence, providers must meet NHSI's licensing criteria. Independent providers that are licenced by NHSI are subject to its oversight.

⁴²NHSI is the organizational name for a group of organizations brought together on 1 April 2016 consisting of Monitor, NHS TDA, Patient Safety, the National Reporting and Learning System, the Advancing Change Team and the Intensive Support Teams. Both NHS TDA and Monitor have statutory powers. NHS TDA has a statutory power to ensure improvement in the quality of the provision and the financial sustainability of NHS services (paragraph 2(2) of the NHS TDA Directions). (Monitor has a statutory power to protect and promote patient interests by promoting economic, efficient and effective health care services whilst maintaining or improving quality (S.62(1) Health and Social Care Act 2012).

⁴³ S.104 of the Health and Social Care Act 2012 in relation to NHS FTs.

⁴⁴ pursuant to paragraph 6(1) of the NHS TDA Directions 2016.

⁴⁵ Except where appointing interim board directors where NHS FTs are in breach of their licence.

⁴⁶ Although NHS TDA can direct an NHS Trust to remove a director.

Meeting NHSI

- 5.4 During the course of the review we had a number of meetings with the senior management team of NHSI including Baroness Dido Harding (Chair), Mr Ian Dalton (Chief Executive) and Dr Kathy McLean (NHSI's Executive Medical Director and COO).
- 5.5 Whereas the CQC might be regarded as an independent inspectorate, NHSI might be described as more of a 'player manager'⁴⁷.
- 5.6 NHSI undertakes 'Well-Led' reviews together with the CQC and on our CQC visit there was an NHSI representative embedded within the CQC team⁴⁸.
- 5.7 Although NHSI does not itself independently inspect NHS FTs and NHS Trusts, it routinely assesses their performance using a tool known as the Single Oversight Framework to ensure consistency of assessment. Further, the NHSI has relationship managers who meet with Boards and senior management and operates a system of Board to Board engagement.
- 5.8 NHSI has the ability to put a Trust into Special Measures⁴⁹ which may be done independently by them or upon the recommendation of the CQC. 35 individual Trusts have been entered into Special Measures since the scheme came into effect in 2013. There are 21 Trusts currently in Special Measures (14 in Special Measures for Quality and/or Quality and Financial reasons and 7 in Special Measures for Financial reasons). NHSI regards itself as less of a regulator and more of an improvement organisation. There are 14 improvement directors who are available to visit, attend Board meetings, or to go on secondment to assist Trusts.
- 5.9 Special Measures Finance was created in July 2016 and is a distinct programme managed by NHSI and focuses upon Trusts with significant quality or financial performance issues.
- 5.10 During our discussions the following views, truths and issues emerged:

⁴⁷ In relation to NHSI's full functions please see further below in Chapter 5

⁴⁸ The 'Well-Led' framework was developed jointly by CQC and NHSI as part of the further development and alignment of their respective oversight and regulatory regimes.

⁴⁹ The Special Measures regime was established by the CQC, Monitor and the NHS TDA following the Keogh Review in 2013. The legal underpinning for the regime consists of Monitor's enforcement powers in relation to NHS FTs in breach of licence conditions and the TDA's powers of direction in relation to NHS Trusts.

Competencies

- (a) The view was expressed that currently the test, in so far as competence and qualifications are concerned, is a moveable feast and depends in part on how badly the prospective employer needs to make an appointment.
- (b) NHSI recognise that there is an issue with recruitment into the senior management of the NHS and the pool of available aspirant directors is shallow. There is a specific problem encouraging doctors to apply as it is regarded as a difficult and potentially dangerous career move. Tenure is very short and the risks are perceived as very high.
- (c) NHSI can't apply the test because it is not the employer. Someone could pass the FPPT at one employer but fail it at the next. There is a need to consider whether the ownership of the FPPT by the employer alone has outlived its usefulness.
- (d) A 'gateway' for senior managers was discussed and possible systems suggested which involved assessment, setting standards of ethical behaviour, a national management talent system, accreditation or a registration system.
- (e) A 'gateway' through which every executive must pass might work as part of a talent scheme: 'you would need assessment centres, standards of ethical behaviour, a national talent management system, an accreditation system or registration system, a kite-mark system'.
- (f) Managing talent from the beginning of a career is not well managed in the NHS as it was traditionally regarded as the responsibility of the individuals concerned or the organisations they worked for. The NHSI is trying to build this concept back into the system.
- (g) There was strong support for the concept of training and teaching the skills required to make a good CEO and Board director.
- (h) Any accreditation/competencies-based system has to allow for transfers from non-NHS systems and from those coming from overseas health systems. The system also has to deal with those coming from widely different backgrounds, some from finance, some from professional regulation, some from NHS management and others with a medical background. There is currently no defined training programme. Any training course needs nuancing, however there are core competencies which are required by all.
- (i) If it could, the NHSI would like to implement a senior management registration system. If the purpose is to prevent people moving around the system, then

any employer-based system is limited in effect. The advantage of a system not owned by individual employers is that it should be more objective and has a wider remit.

- (j) It was pointed out that national registration (of Trust senior managers) was recommended in 2001 by the Bristol Inquiry (but was never inserted into legislation).
- (k) NHSI envisaged any list being a more basic gateway which provides a 'floor' above which someone is defined as being suitable for a director level position. NHSI could also explore the potential for a role in a 'second level' to any proposed gateway system to enable assessment for specific roles.
- (l) It was the NHSI view that all directors of an NHS Trust need to understand each part of the Trust before aspiring to be a director, so nurses and doctors need to understand the importance of financial governance and the financial officer and CEOs (if not a doctor or nurse) need to understand the health system and clinical governance.
- (m) CEOs need to understand health care; they need to understand the leadership of doctors and nurses; they need to understand finances. These are fundamental leadership capabilities – not much has been done to train doctors about leadership.
- (n) There would need to be differentiation for different kinds of senior managers (e.g. CFO/CEO). There would need to be a capability test linked to performance in the organisation. The FPPT should cover all Board members.
- (o) The variation in how executives are recruited is huge. At one end of the scale, there is a 'full service': full stake holder discussions are held with each candidate, applicants are filmed in order to test media training etc. At the other end of the scale, there is just an interview panel for between 45 and 60 minutes with little other than CVs and references.

Database

- (p) In terms of its ability readily to access information about the senior management of Trusts, there is a lack of data and no history about individuals that the NHSI is able to look at. The responsibility for recording such information is still regarded as the business of individual employers. The only way of delving into a director's history is to make inquiries with the current employing Trust and ask 'what was on the CV' although the NHSI does in fact have information gathering powers. Some Trusts retain little other than a CV

and a bland reference and there is no standard criteria or toolkit in relation to the interview process for directors.

- (q) The NHSI would be content to host and manage a centralised database and did not see that this would be affected by the joint working arrangements being developed with NHS England.
- (r) There are multiple ways in which past performance of a CEO could be checked (and records kept) – on finance, people, care, quality. One could look at the following: accounts; the staff survey; inpatient survey; whistleblowers, MPs; and patients.

References

- (s) In relation to the availability of information in the system about directors, the quality of references was mentioned as an important issue and there was said to be significant room for improvement. Central guidance on the information required to be provided in references would be helpful; they are currently of variable quality and individuals need to be held accountable for filling them in completely, appropriately and accurately. ‘Vanilla’ references (which are now the norm) are unhelpful.
- (t) One of the difficulties of applying the test when things have gone wrong is that people often leave directorial posts before disciplinary proceedings are begun, and without getting to the final point in the process. There may therefore be no disciplinary process or finding made against them and they move with a vanilla reference which does not reveal the real background.

Expanding the FPPT

- (u) We were told that there is a case to be made for extending the FPPT down to any managerial post, and that it is also illogical not to extend the test to CCGs and to others. There is a separate debate in relation to third party suppliers (management consultancies and service advisers) which is outside the scope of this review.
- (v) The benefits of keeping current focus is that it is limited but if one of the objectives is to stop people taking senior roles in other parts of NHS, it is illogical not to extend the concept of the test to CCGs and others. The current breadth is in this sense inadequate.

Ability to disbar directors

- (w) There was recognition of the revolving door problem, and historically non-provider organisations within the NHS family have been seen as one of the

repositories of the 'failed' directors⁵⁰. We were told that this route had now stopped, and that NHSI would not now facilitate sideways movement in the NHS which has been traditionally seen as one of its roles.

- (x) If there are to be sanctions against poor directors then a gradation of sanction should be considered. Further it should be recognised that when things go wrong, although the Chief Executive is often targeted for blame, it normally reflects a failure by the entire Board. It would be useful to have temporary and permanent features to distinguish those who can be remediated from those who cannot.
- (y) A barring system would be cheaper but the perception of it would not be as positive as a register. A barring system would prohibit those who had crossed a line, but it might be seen as a further message about sanction and negativity. It might also reduce the pool of applicants. The 'chilling effect' would need to be carefully balanced with a positive message.
- (z) There would also need to be consideration for a statute of limitations, for example on the maximum length of time for exclusions. This is important not just for a fair view of the length that any exclusion system would go, but also in terms of helping people grow. But there will always need to be some exclusions which are not time-limited, for the most serious issues.
- (aa) Further, there would need to be consideration of an independent appeal structure, possibly to the Health, Education and Social Care Chamber of the First Tier Tribunal.

Amending the Regulation

- (bb) The FPPT itself is applied inconsistently and is difficult to interpret.
- (cc) The FPPT has not in practice led to many people being identified as being unsuitable.

A central database

5.11 The application of the FPPT is currently hampered by the lack of information about directors. The quality of the information held by Trusts is very variable and there was a strong sense that the information should be standardised and retained more cohesively and centrally.

⁵⁰ Although we understand that NHSI has never employed a former director who has been found not to have met the FPPT.

Overview - accreditation and training

- 5.12 The complaints and concerns expressed about the lack of a cohesive accreditation and training system for managers are merely reflective of many previous reports. Lord Rose commented in his report in 2015:

"Closely related to performance management is talent management. **There is no central talent pool or NHS-wide structured talent management scheme in place.** This is the case for general management, for clinicians and for both Trusts and CCGs. **The creation of a talent pool on a national scale has been attempted by the NHS on a number of occasions; clearly one size cannot fit all NHS organisations; but there must be a rational attempt to improve what there is now.**"

- 5.13 Later in his report he commented:

"It is important to maintain quality, pluralism and innovation in training courses, these should be available in various locations across the country. Training courses should have status, appeal and impact for those staff taking them; they should also be substantial enough to allow people time to reflect on what they have learned, and to form cohorts with their peers. For the NHS these courses should be diverse, accredited, and flexible. This form of collective and action learning is invaluable in developing both individual and organisational competence."

- 5.14 As mentioned in the introduction, to say that the NHS is not a cohesive service is something of an understatement. One IP described it as a 'Federal state', another went further and described it as 'atomised'⁵¹. It is clear that the concept of Foundation Trust status has furthered that federalism and taken Trusts further from a central command and control model. While the purpose of that was we understand to remove successful Trusts from the vicissitudes and whim of whatever current government was in power, it has led to the creation of a series of semi-independent states. Several previously successful Trusts which attained Foundation Trust status are now, we were told, in Special Measures. There is no clear distinction in terms of quality of FTs and non FTs. There are no Trusts now in the FT pipeline.

- 5.15 As Lord Rose pointed out in 2015:

⁵¹ These comments were not made by the NHSI IPs.

"Trusts are resolutely separatist, silo organisations; often they think tactically rather than strategically. They are therefore not keen to lend out staff, and consequently both the individual and the organisation feel unable to grow (this is a particular problem at middle management level). Chief Executives expressed concern over the challenge of taking on the more difficult Trusts: they saw them as isolated outposts with no central protection."

- 5.16 The concept of a talent pool and accreditation is not a new idea. Again, it was prefaced in recommendation 8 of Lord Rose's report:

"R8: Require senior managers to attend accredited courses for a qualification to show consistent levels of experience and training have been reached across the NHS. On completion of this course they enter a senior management talent pool open to all Trusts."

- 5.17 He went on:

"It is crucial for the future of the NHS that it creates and supports a cadre of capable, trained and current managers from all disciplines and increases its level of cultural diversity to better reflect its staff."

- 5.18 The question might be asked: if the FPPT is simply there to stop poor managers moving around the system, what has training got to do with the application of the test? Our answer is, 'everything'. The FPPT should not simply become a test to disbar poor or badly-behaved directors; its focus is not only upon the dishonourable, reckless and unscrupulous, (of whom there are fortunately very, very few), but upon competence and qualification to undertake the director's role.

- 5.19 Having considered the idea of a gateway and accreditation system for directors carefully we have resolved to recommend a more modest and nuanced approach which is one of required competencies (dealt with later in this report). An accreditation system would require a fully-fledged regulator to administer it and there was relatively strong resistance from the majority of those we spoke to, to imposing more formal regulation than was absolutely necessary.

- 5.20 We also deal later in this report with our recommendation to set up a disbarring service for directors found guilty of serious misconduct. We mention it here however because consideration will have to be given to siting that service within NHSI.

- 5.21 NHSI would in our view be the obvious organisation to house a disbarring service. The independence from central government and the Department of Health and Social Care of the NHSI role in this regard would have to be fully managed and

respected. The FPPT applies to all providers registered with the CQC in respect of a regulated activity and is therefore one lever which may be used to enhance the quality of senior management across almost the entire service. However, any introduction of a power to disbar would have to go hand in hand with the bolstering of training and development for directors and aspirant directors.

Conclusions and recommendations

- 5.22 Although the NHSI indicated support for the concept of a gateway accreditation service, we have not for the purposes of this review felt it appropriate to meet that aspiration. Any accreditation service of directors would require an extensive system, not only to evaluate the qualifications and competencies of each director and potential director, but also to create a system of regular reassessment.
- 5.23 There would be a danger, unless such a system were carefully nuanced, of falling into the error which we wish to avoid of removing or minimising the responsibility of Trusts to employ the right person for the right job. We have however recommended that there should be certain core competencies identified ([Recommendation 1](#)) which should be designed and set down in the regulations against which all directors of health Trusts should be able to be assessed.
- 5.24 Unless the directors have those competencies, they should not be able to meet the fit and proper test unless they acquire them by training or development.
- 5.25 The NHSI will have a central function in setting those competencies together with National Health Service Leadership Academy and the CQC.
- 5.26 We have recommended that this system be kept under review and that consideration may have to be given in due course to setting up a more prescriptive fully fledged regulatory system for senior directors if there is evidence that the required core competency system is insufficient.
- 5.27 We have also formed the view that there does need to be a barring system for those guilty of serious misconduct ([Recommendation 5](#)). We have dealt with this fully in [Chapter 9](#) – A power to disqualify. Subject to ensuring independence we have recommended that the NHSI is the right organisation to develop and house the necessary council which will have both investigative powers and a tribunal function.
- 5.28 NHSI will also have the task in conjunction with others of setting down what types of behaviour amount to serious misconduct. We have made recommendations in relation to what we feel those behaviours should be, but it will be for others to design and develop those.

6. Management Qualifications and Training

Competence and qualifications – the lack of transparent competencies, assessment and training for the Board

6.1 There was support among the majority of IPs both for the concept of a gateway into a pool of senior managers and for more extensive training and preparation for Board membership. This has already been prefaced in [Chapter 5](#). The purpose of this is not only to pave the way for aspirant directors but to ensure a consistency of training and to increase the diversity of those willing to apply for such roles. We were told that almost one third of Trusts had at least one vacancy at Board level or at least one interim director. The recent [King's Fund report](#) (July 2018) found:

"Leadership vacancies in NHS Trusts remain widespread with 37 per cent of all surveyed Trusts having at least one vacant post for a Board-level executive. The highest vacancy rates were for director of operations and director of strategy roles."

6.2 Lord Rose in his 2015 leadership review said:

"Talent cannot be managed without a single competency framework for all NHS staff. There isn't one. This absence, combined with the lack of a systematic appraisal, makes development and deployment of key talent almost impossible. Consistent use of competency frameworks and appraisals help set standards. Throughout the NHS there appears to be a marked lack of holding people to account for their performance. The NHS is still seen to routinely move staff upwards or sideways, not out, even when they're not performing. This must stop.

Clinicians contributing to this Review felt they were treated differently from general managers in that they find themselves under greater and more stringent scrutiny. Moving a poorly performing manager essentially rewards incompetence or semi-competence; although it is extremely difficult to sanction or remove a clinician, the stakes are high for that individual (he or she can be struck off the medical register). There is a need here to level the playing field.

Second, there is a chronic shortage of good leaders in the NHS. Leadership can be taught and learned. Bringing into the NHS people at

higher levels is not the whole answer. Rather the NHS needs greater diversity by bringing people into leadership at all levels."

6.3 The Patients Association was informative:

"Overall, we do not consider that the current FPPR is meeting its objective. There seems to be little evidence of the introduction of FPPR having made a difference to the arrangements for employment and redeployment of NHS senior managers and executives.

The link between poor management and leadership on the one hand, and bad patient experience on the other, is now increasingly well understood. It is also clear that financial pressures within the NHS compound the effect of this link, by making NHS institutions more prone to failings at a leadership and management level that can harm patients at scale.

There is therefore a clear, if complex, through-line from the appointment of effective leaders, and necessary processes to hold them to account, to the experiences of patients. It is vitally important that the FPPR is implemented properly and meets its objectives, in order to establish an open and just culture that promotes patient safety in the NHS."

6.4 These views were reflected in much of the evidence we heard in the current review. We were persuaded that the test is ineffective in ensuring that directors have the right skills and that, where those skills are lacking, the deficiencies are identified and corrected. We were also persuaded⁵² that leadership skills can be taught, and that directors' development is critical for good management and an increase in diversity at Board level.

6.5 In our view a gateway should not consist of any sort of entry exam but a set of competencies which aspirant directors ought to be able to meet before entering Board level directorships. This is intended to ensure that only those with specific defined competencies may hold a health-related director's post. This is also intended to encourage diversity by assisting and enabling those who might not otherwise consider a Board position to identify the required competencies.

6.6 Deputy Chief Executive of the NHS Confederation Danny Mortimer impressed upon us:

⁵² By Baroness Harding and Ian Dalton from NHSI amongst others.

A REVIEW OF THE FIT AND PROPER PERSON TEST

"I would like to see something that feels less onerous to Chair colleagues but does not over-engineer what it means to be a Board director and if there needs to be greater assessment of how people maintain their Board skills then it is done through existing processes rather than inventing new ones. For those colleagues on NHS Boards at the moment I am nervous of expecting them to participate in new processes to demonstrate their capability."

- 6.7 We recognise that concern and hope that the required competencies we suggest below are criteria which should widely be accepted as required basic competencies for all Board directors. Further, although we have made suggestions as to what those competencies should be, it will be for others within the service to design them fully. We feel the competencies to be set should be no more onerous than that which is genuinely required by any director aspiring to manage a Trust at a senior level.
- 6.8 We would therefore hope and expect that the majority of directors on Boards will already be able to demonstrate that they have such experience and skills.
- 6.9 There was recognition that good managers do not necessarily need to come up through the NHS system, and may come from overseas or from other sectors, but all should have some basic competencies and understanding of the service they are entering. The most qualified, successful and experienced director from retail or finance requires different understanding and skills when entering the health service.
- 6.10 NHSI, in particular, strongly supported management preparation for Boards and felt this would encourage people to apply and thus increase the pool of talent.
- 6.11 Dr Anthea Mowat BMA Representative Body Chair told us:
- "training and the assessment of directors on Boards would be extremely welcome... People are sometimes parachuted in (to director roles) and don't understand what their responsibilities are. ... training needs to be early on."
- 6.12 The importance of not taking the prime responsibility away from the Board for the appointments they make was also frequently underlined. Stephen Hart (CEO NHS Leadership Academy) told us:
- "there is a difference between quality assuring and appointing. What can national bodies do to say these candidates are quality assured. Trusts may choose differently but here is a pool of candidates who are quality assured."

- 6.13 In our view, great care has to be taken here – a central body cannot ‘quality assure’ a particular candidate for a particular job. What can be done perhaps is to ensure that everyone who sits on a Trust Board has proved themselves to have certain required competencies. Whether the qualifications, experience and competencies of the individual are sufficient for the job must ultimately be the decision of the employer, but that decision should be inspected and assessed by the CQC. A Trust which appoints a director lacking a core competency will not expect to do well in a CQC ‘Well-Led’ inspection.
- 6.14 The ideas of leadership training and a cadre of leaders are not novel suggestions having been previously recommended both by Sir Robert Francis and by Lord Rose (see [Chapter 3](#) – Previous Reports).
- 6.15 The point was repeatedly made to us that for some, including some clinically qualified doctors and nurses, the step up to the Board is a significant one. Some training would help make that less of a high step. Similarly, non-clinically qualified managers must understand some of the basics of delivering safe quality care on the wards.
- 6.16 There were once again calls for a stronger leadership cadre in the NHS, a call often repeated in the past. We noted that NHSI run their own aspirant Chief Executive programme⁵³. There are currently over a dozen individuals on the programme at the time of writing. There is also an aspiring Nurse Director programme run by NHSI and an aspiring CEO programme run by the Leadership Academy. NHSE have a leadership academy and a nurse director programme. The Institute of Directors runs a number of courses for aspiring Board directors as do many other providers.
- 6.17 We spoke to Stephen Hart (CEO) and Peter Homa (Chair) of the Leadership Academy. The Leadership Academy, formed in 2012 under the auspices of Health Education England, also runs a number of courses designed to train and assist aspiring health service leaders including the Nye Bevan programme for aspirant directors. Examples of such courses include:
- Introduction to healthcare leadership’
 - ‘Looking to step up to your first leadership role?’
 - ‘Ready to lead larger functions, departments and more complex projects?’
 - ‘Develop your role as a senior leader with an aspiration to hold a director-level role in the next two years?’
 - ‘Aspiring chief executive and want to prepare for one of the most challenging roles in the NHS?’

⁵³ This is a collaboration between the NHS Leadership Academy, NHSI and NHS Providers

- 'Already in a chief executive role?'

6.18 Recognising that the NHS has fallen behind other sectors in talent management, the Leadership Academy states:

"... the NHS Leadership Academy, in partnership with national, regional and local partners, is leading a change to the way talent management is approached and practiced in the NHS. The objective is an NHS with the culture, systems and processes in place to identify, develop, deploy and support leaders at all levels into roles that best suit their development, and the service's needs.

At the heart of this talent approach is the inclusion imperative. It is a sad fact that successive initiatives in our NHS have failed to raise the representation of black, Asian and minority ethnic (BAME) colleagues at the most senior levels. The NHS talent approach of the future will centre around inclusion from the start. Lessons are already being drawn from other sectors where novel approaches and self-nomination, rather than 'tapping on the shoulder' are supporting shifts in representation."

6.19 A regional Talent Board has been set up in the Midlands and East of England. The ambition is described as follows:

"Our ambition for the first Regional Talent Board in England is that we can start to identify, develop, support and deploy leaders at all levels much more effectively. Aspire Together will help to deliver compassionate, inclusive leadership, which is key to a high quality and sustainable health and care system."

6.20 We were told:

"We want to construct a programmed way of developing talent across the NHS recognising talent across the arc of person's lives. We want an authentic appraisal system and records which track the history of the individual and then you can better match the challenge and skills of the individual (to the job)."

6.21 Part of the aspiration of the talent Board is said to be:

"Creating a diverse talent pool of future senior leaders. At the same time, we want to see a more systemised approach to how we nurture our aspiring senior leaders. Individuals will have the opportunity to become part of a regional talent pool with rigour, consistency and transparency at its heart. This will give organisations a quality assured

pool of candidates from which to select when appointing to Board and governing body level posts."

6.22 This clearly chimed with our own thinking and with that of report writers before us.

6.23 NHS Providers was concerned about an accreditation system. They posed the question: who would accredit, what would they be accrediting given the absence of consistently used leadership / management qualifications and how burdensome would such a system be? They argued that a comprehensive accreditation scheme ran the risk of being excessively burdensome and expensive. They did recognise, however, the importance of Trusts having an appropriate obligation to ensure their leaders were capable of doing the job required of them and that the FPPT had a role to play in this process.

6.24 In this context, NHS Providers accepted the importance of Board members having training in Board leadership and a full induction. Examples of areas they said they would expect a Trust induction / training programme to cover included:

- What the Trust does
- NHS finances
- Board responsibilities
- Clinical governance information
- Effective risk management
- Patient perspective
- Data to look for
- How to tell if something is going wrong

6.25 We agree with that sentiment and have suggested relevant competencies which meet those criteria and go further.

6.26 There is force in the concerns expressed by NHS Providers and others about the setting up of a fully blown accreditation system but although we have pulled back from such a recommendation we do feel that will need to be kept under review.

6.27 We are not suggesting that all current directors should have to undertake further training. However, our view is that all should be able to demonstrate that they can meet certain required competencies and if not should be required to gain them within a short period. As Peter Homa told us:

"I don't think there should be mandatory training, but a truly effective appraisal system of everyone including Director level which will identify gaps.

If as a CEO you are not concerned about your personal and professional development then you will atrophy."

- 6.28 Even the most experienced Chief Executives to whom we spoke were not averse to considering further training and regarded personal development as well as Board development as both helpful and important.
- 6.29 It was made clear that the NHSI view was that all directors of an NHS Trust need to understand each part of the Trust before aspiring to be a director, so that nurses and doctors need to understand the importance of financial governance and the financial officer and CEO need to understand the health system and clinical governance.
- 6.30 Interim directors, of whom we heard there were at times a significant number in the service must also in our view meet the Regulation 5 test. All of the relevant criteria of competence and qualification applying to a permanent post director should plainly also apply to all interim directors.
- 6.31 Training for the Board was also cited as an important feature in encouraging diversity.
- 6.32 We were told by the Chief Nurse (Jane Cummings) that there was evidence that although nurse empowerment was progressing at ward and theatre level, nurses entering the Boardroom sometimes have less confidence to speak up and their contribution is not deemed as valuable as others. This is obviously wrong and needs to be redressed. We were told that the right training would do much to assist.
- 6.33 Stephen Hart (Leadership Academy) told us about the setting up of the national and regional talent pools. It is intended that there will shortly be convened a National Talent Pool (NTP) (sitting above various Regional Talent Pools) which will sit within NHSI. The NTP will set the strategic direction for the service. The purpose of the NTP is talent management and ensuring the NHS has the right number of senior leaders able to occupy senior positions. However, it has not yet (at the time of writing) convened.

Board development and appraisal

- 6.34 It was clear from those to whom we spoke that Board development and appraisal was considered an important part of ensuring the Board and each of its directors were competent in their roles. The NHS Leadership Academy espoused 6 monthly appraisal as well as 360 degree assessments to include external assessment. However, we were also told that appraisals could be conducted in very variable ways and were pretty vanilla.

- 6.35 Appraisals, including 360 degree appraisals should, if properly conducted, help to winkle out problems before they become failures or disciplinary issues. Professor Stephen Powis (National Medical Director, NHSE) also regarded it as a system to identify where support might be necessary before problems arise. There is much to be said for at least a portion of a 360 degree appraisal being from anonymous sources not chosen by the candidate. We noted that all senior civil servants are already subject to annual 360 degree appraisals.

Revalidation

- 6.36 In speaking to the GMC it was interesting to note that in their view (supported by some research) revalidation is becoming a more accepted part of the process for doctors on the GMC register. We explore what the GMC does further in [Chapter 11](#). Whilst revalidation may originally have been widely regarded as a box ticking exercise some of the benefits of required self-evaluation and assessment are said to be beginning to demonstrate themselves even if still for a minority.
- 6.37 We also think that there is value in considering the responsible officer role in connection with directors as well as a regional responsible officer to provide oversight and consideration on a continuous basis of whether the construct and training of each Board meets the current needs of the Trust concerned.
- 6.38 Revalidation of doctors in senior management roles still seems to be less well defined as a process than it is for doctors in purely clinical roles. However, Professor Powis told us that any doctor who is a director should at appraisal be expected to provide evidence that they are currently competent to undertake the role, and that their revalidation process should contain an appropriate focus on management skills as part of an assessment of overall scope of practice.
- 6.39 Dr Susi Caesar (the Royal College of General Practitioners' Lead for Revalidation and the Chair of the Revalidation and Professional Development Committee of the Academy of Royal Colleges) was convinced that not only are regular appraisals of great importance but that appraisals can be empowering. In a recent RCGP survey one third of GPs undertaking revalidation thought that the appraisal had made a positive improvement to their work. Although that signifies that two thirds did not, much depends we were told on the quality of the appraisal system and the appraiser involved. She impressed upon us the importance of the involvement of an external independent appraiser.
- 6.40 Dr Caesar also impressed upon us the importance of regular self-improvement for Board directors and sharing best practice as part of that both on an individual level and at Board level. Bringing in to the development process successful system leaders who can share best practice would be widely welcomed.

A REVIEW OF THE FIT AND PROPER PERSON TEST

- 6.41 Individual director's appraisals are part of modern commercial life but are not yet seen on every Board in the NHS. This is despite the very large sums of public money expended by them and their overriding duty to the patients and public they serve.
- 6.42 Revalidation for nurses is in its relative infancy having been introduced in 2016. Nevertheless, nursing directors will be subject to revalidation.
- 6.43 It follows that while doctor directors and nurse directors have to submit to revalidation and, at least technically, could lose their registration should they fail to comply, other non-medical directors currently have no such requirement. We think the field should be more balanced.
- 6.44 Further, the framework for revalidation could lead the principles of a Trust's annual appraisal for directors. The revalidation toolkit and criteria which covers the issues of character, qualification, skills, experience, health, probity and misconduct, is in place and adaptable.
- 6.45 Appraisal information and summaries are held by designated bodies for the doctors that connect to them. These records go back six years to 2012 when revalidation was introduced. There is current debate about how long these records should be held into the future.
- 6.46 Whilst we do not suggest a full revalidation programme for directors, the concept of self appraisal and 360 degree appraisal ought to bring some benefit to those who embrace it.
- 6.47 We noted the proposal for the appointment of a Chief People Officer who will be responsible for developing and extending the talent pool for senior positions. This role may fit well with a national responsible officer post for senior directors. No appointment has been made at the time of writing.

Conclusions and Recommendations

- 6.48 We have not recommended a mandatory assessment gateway. We have however adopted a required competencies model without which no director will qualify as a Fit and Proper Person ([Recommendation 1](#)).
- 6.49 In our view a careful analysis of required competencies of a Board level director, or their equivalents, must be undertaken and although we have suggested certain core competencies, these will need to be assessed and tested by others. It may well be that competencies other than those we have identified are needed to perform a Board director's function. Each director should be able to evidence those competencies or if not, to attain them by way of training or development

within a short time period. The competencies will need to be nuanced for different types of health service.

- 6.50 Caution was advised in terms of requiring the accreditation of courses, there being so many potential providers, and there was no appetite for the creation of an OFSTED style system for accredited providers. Short of this we suggest that the competencies are set as carefully as possible and it would be up to the course providers to ensure that training is provided adequately to meet those required competencies either as a single course or separated into individual modules. Trusts' appraisals of directors ought then to identify any weak points where they exist.
- 6.51 Once the competencies have been defined and set, it will be for the Trusts to ensure that each of their directors can meet them, and where they cannot, to ensure that training is undertaken.
- 6.52 We envisage that the CQC will then inspect and assess whether a Trust is 'Well-Led', by reference in part, to whether there is evidence retained by the Trust that each director can evidence the required competencies and that they are up to date. This means that each director should have a personal development plan and be able to demonstrate recency in their development and training.
- 6.53 Regular appraisals are an important part of Board assessment and director development. In good Boards these are done regularly, but this does not seem to be universal by any means. In order to demonstrate compliance with the competencies Board directors will need to be able to demonstrate recency of the skills required and there should be consideration given by the CQC to the recency of the evidence available.
- 6.54 The competencies themselves should also be regularly reviewed.
- 6.55 We have not at this stage recommended a fully blown regulatory system because we feel that with appropriate extra focus on required competencies and Board development the CQC ought to be able to use its inspection regime to further encourage director and Board development. Should that not succeed in improving directors' training and development, then in due course a more onerous and regulatory style regime may need to be considered.
- 6.56 The relevant competencies need to be designed by those within the system and there will need to be distinctions between NHS hospital Trusts and, for instance, ambulance Trusts. NHSI, Health Education England, the NHS Leadership Academy, the Royal Medical Colleges and others should all be involved in the design process. We recommend, therefore that NHSI should, in consultation with other bodies such as the NHS Leadership Academy and the Academy of Royal

Colleges, define, design and set required competencies which must be met by any person holding or aspiring to a directorship post (including NEDs and interim directors) ([Recommendation 1](#)). Further, we suggest that some of the core competencies should include a knowledge and understanding of the following for all directors including NEDs:

- Board governance;
- Clinical governance;
- Financial governance;
- Patient safety and medical management;
- Recognising the importance of information on clinical outcomes;
- Response to serious clinical incidents and learning from errors;
- The importance of learning from whistleblowing and ‘speaking up’;
- Empowering staff to make autonomous decisions and to raise concerns;
- Ethical duties towards patients, relatives and staff;
- Complying and encouraging compliance with the duty of candour;
- The protection, security and use of data;
- Current information systems relevant to health services;
- The importance of issues of equality and diversity both within the hospital in workforce issues and in relation to appointments to the Board; and
- An understanding of the importance of complying on a personal basis with the Nolan principles.

6.57 Plainly different director posts on different Boards will require further and perhaps other competencies, qualifications and training. This set of competencies is only intended as a basic starting point. The Trust’s duty to appoint appropriately qualified people to the appropriate posts must be continuously underscored.

6.58 In designing the competencies we felt that there may be some benefit in considering the model provided by [S172 of the Companies Act 2006](#) but designed for a health care related context:

(1) A director of a company must act in the way he considers, in good faith, would be most likely to promote the success of the company for the benefit of its members as a whole, and in doing so have regard (amongst other matters) to—

(a) the likely consequences of any decision in the long term,

(b) the interests of the company's employees,

A REVIEW OF THE FIT AND PROPER PERSON TEST

(c) the need to foster the company's business relationships with suppliers, customers and others,

(d) the impact of the company's operations on the community and the environment,

(e) the desirability of the company maintaining a reputation for high standards of business conduct, and

(f) the need to act fairly as between members of the company.

(2) Where or to the extent that the purposes of the company consist of or include purposes other than the benefit of its members, subsection (1) has effect as if the reference to promoting the success of the company for the benefit of its members were to achieving those purposes.

(3) The duty imposed by this section has effect subject to any enactment or rule of law requiring directors, in certain circumstances, to consider or act in the interests of creditors of the company.

6.59 The Institute of Directors has published an IoD Academy Director Competency Framework, which contains fifteen core competencies across three dimensions: skills, mind-set and knowledge.

6.60 We recommend that the CQC should, during the 'Well-Led' inspection, review the evidence including sampling available appraisals in respect of the directors on the Board to ensure that they are currently able to meet the mandatory competencies, are further suitably qualified to undertake their function, have regular appraisals and are up to date with personal development plans

6.61 We recommend that this approach be kept under review with consideration to be given in due course as to whether a more formalised gateway, registration and validation system is necessary to ensure all directors have acquired the necessary competencies.

7. Extending the reach of the test

7.1 It was recognised by almost all information providers (IPs) that one of the factors which facilitated the revolving door mentality and the ability of unfit persons to move around the health services was that the FPPT only currently covers providers of healthcare and does not include commissioners or ALBs.

Commissioners, NHSE, CCGs and ALBs

7.2 We had the advantage of speaking to the senior management team of NHS England (NHSE) including Professor Jane Cummings, Professor Stephen Powis and Dr Mike Prentice (Regional Medical Director who leads on Professional Standards).

7.3 In our discussion with NHSE and also with representatives of Clinical Commissioning Groups (CCGs) there was general acceptance that in order to bolster the strength and width of the test, as well as to put a stop to ‘the revolving door’, the FPPT should be extended to commissioners including NHSE and CCGs as well as other Arms-Length Bodies⁵⁴. It was described as ‘incongruous’ that it did not apply to commissioners, to NHSE itself and to NHSI and to other ALBs within the NHS system.

7.4 Clinical Commissioning Groups currently commission the vast majority of NHS services (currently around £73.6 billion). NHSE commissions a relatively small part of the services provided and those tend to be in specialist areas accessed by few.

7.5 Each CCG must have a chair and an accountable officer. Members of the CCG, who will not necessarily be directors, will include secondary care specialists, GPs and lay members. NHSE has the role of holding CCGs to account.

7.6 So far as CCGs are concerned there is already guidance available, including the [Senior Appointments Guidance](#) published on October 2015.

7.7 The guidance includes advice on the appointment of Accountable Officers (AOs) and senior CCG appointments. It provides in part that:

“10. CCGs are responsible for the recruitment and selection process for the appointment of chair of the governing body, AO and CFO⁵⁵. NHS England plays a particular legal role in the appointment of the AO.

⁵⁴ See Appendix 2 – list of relevant Arms Length Bodies

⁵⁵ Chief Financial officer

11. CCGs will be responsible for ensuring the recruitment and selection process ensures that any candidate appointed to senior positions can demonstrate the experience and skills required for that post. This will include professional qualifications where appropriate, for example the CFO. Recruitment and selection should give CCGs assurance that individuals have the skills and competence to take on these senior roles.

12. It would be beneficial for potential AOs to undertake an assessment centre to ensure their suitability to the role. This could be sourced for example through their NHS Leadership Academy local delivery partners. Any such programme should be funded by the recruiting CCG.”

7.8 NHSE already provides oversight in relation to the appointment of the Accountable Officer via the Director of Commissioning Operations (DCO) and the guidance provides:

“24. Once the recruitment exercise is concluded the CCG must notify their relevant Director of Commissioning Operations (DCO) by submitting a new appointment pro forma (annex 2), along with a letter from the chair of the CCG making their nomination for a new AO. This submission must include details of the recruitment process and the steps the CCG has taken to assure itself of the AO designate’s fitness for the role. CCGs may wish to seek advice in advance from NHS England on how the CCG can assure itself of the candidate’s fitness for the role, such as use of an assessment centre, and support in the recruitment and selection process. CCGs may wish to invite DCOs to sit on selection and interview panels.

25. The DCO team will assess the process that the CCG has undertaken, ensuring that the CCG has followed robust procedure before submitting the nomination to their Regional Director. If the proposed appointment is not supported by the DCO or Regional Director the nomination will not be progressed to the next stage of review. Once reviewed by the Regional Director, the pro forma and supporting documents will then be sent through to the Central Planning and Assurance team for action.”

7.9 Considering the systems already in place we do not consider that the extension of the test to CCGs ought to be onerous and we assume records of each appointment are available. The extension would in any event only apply to the executive officers of CCGs.

- 7.10 There are a number of Arms Length Bodies (ALBs) within the NHS family, which have historically accepted senior executives from across the system. We have been urged by many to ensure that the test applies as far as practicable, system wide.
- 7.11 That commissioners and relevant ALBs should have to comply with the same rules as those sitting on the Boards of Trusts delivering the care commissioned and regulated, seems obvious.
- 7.12 There is however a logistical and practical problem. Who could oversee the test as it applies to commissioners and ALBs? The test sits within regulation 5 and the application of it is overseen by the CQC. The CQC has no oversight role in relation to commissioners or ALBs. While NHS England might be the obvious body, they also commission certain services and if the test is to extend to CCGs it ought logically to apply also to the NHSE which could not legitimately regulate itself. Because of the limited role we envisage to be taken by the HDSC we do not suggest that the oversight should lie with it.
- 7.13 The remaining possibility would therefore be to place oversight with the NHSI and to do so would require legislation. An alternative would be to leave the responsibility with the Department of Health and Social Care. Recognising the complexity that may lie ahead, we will recommend that a scoping exercise be undertaken with a view to a form of the test being extended by statute to apply to CCGs, NHSE and other ALBs including the CQC but that in the meantime the Senior Appointments Guidance be updated and the principle components of the FPPT be adopted.

Wales, Northern Ireland and Scotland

- 7.14 We have no remit so far as the jurisdiction of Wales, Northern Ireland and Scotland are concerned but, should our recommendations be followed in England, we would further recommend that the devolved governments and health services give consideration as to whether there would be any benefit in applying our recommendations to the health services of those countries. We understand that the movement of directors who have lost their posts from England to those countries has not been unknown.

Other management positions

- 7.15 There were a number of requests that we recommend broadening the test to all those in senior management positions or even below that level.

- 7.16 Given the task we are recommending with respect to the setting up of a comprehensive database which, in our view, is a critical part of making the test effective, we do not think it wise to seek to extend the test further down the line of management at this stage. Furthermore, the required competencies would potentially become more complex and intricate. Should our recommendations be followed and lead to benefits in the system this is a matter which can be considered further in the future.

Regulators – CQC, GMC, NMC and others

- 7.17 We were invited by some to recommend extending the FPPT to other medical regulators including the GMC, NMC and beyond. There are substantial practical difficulties in doing so including the issue of who would regulate such a scheme. Further, we are satisfied that no health regulator is likely to choose to employ anyone at a senior level who has been disbarred by the HDSC for Serious Misconduct. We do not therefore think it is necessary to make recommendation in this respect.

8. Information and records about directors

The issue

- 8.1 There is a significant issue in relation to the availability of information about Board directors within the NHS service. There is no centrally held list describing such basic information as to who a director of which Trust is; who is Chief Executive or Chair of which Trust; who is the Medical Director or Nursing Director or Chief Financial Officer etc. Even the Department of Health and Social Care (DHSC) is reliant on performing an internet search to discover who is where. The importance of this is that each Trust employing a new director is reliant upon what that individual produces to the Trust by way of a CV and background information.
- 8.2 More importantly there is no central or comprehensive history of the individual involved: where they have been; what their qualifications and competencies are; what checks have been done on their backgrounds; how they have performed; what their appraisals have recorded; what complaints have been made about them and upheld, etc; Each time an individual applies to a Trust for a director's position the Trust has to perform the checks afresh.
- 8.3 Although initially we were told by one IP that the keeping of core information about each director would be 'a massive task' we do not accept that description. It pales into insignificance when compared to the records kept by the armed forces (over 150,000 records), or Ofsted which inspects and regulates children's care homes and records details on 66,000 managers and 24,500 group providers. Further, there is a basic database of teachers that holds more than 2.8 million records with 550,000 active in the workforce; the General Medical Council hold records of 250,000 doctors registered with a licence to practise as do the General Dental Council in relation to dentists.
- 8.4 With an average of twelve directors on each Trust Board the total numbers in relation to those about whom records would have to be retained would, we estimate, be under 3,500 with the addition of those currently out of the system who may return.
- 8.5 Furthermore, most of the information we recommend should be recorded is the sort of information which ought to be held by Trusts in any event if it is to pass a CQC 'Well Led' inspection.
- 8.6 The body from which we received push back on this issue was an important one, namely the NHS Providers. We were fortunate to have two meetings with Chris

Hopson the Chief Executive as well as meeting at a round table discussion with two Trust Chief Executives and a Trust Secretary. This was of course in addition to the numerous other Trust Chief Executives and Chairs we were fortunate enough to meet on other occasions.

- 8.7 NHS Providers is the membership organisation and trade association for NHS hospitals, mental health, community and ambulance services. NHS Providers has all 227 Trusts and Foundation Trusts in membership and acts as their public voice to help shape the system in which they operate, including acting as a formal responder, on behalf of the sector, to major policy consultations that affect their members. Their firm view was that the best place for information about each director was in the Trust itself - **"People's natural reaction will be that it [a centrally held register] will be an extra level of bureaucracy."** We were told:

"The CV will tell you where they have been and our view is that it is the Trust's responsibility to make appropriate pre-employment checks."

"The FPPT places a duty on Trusts to ensure they do their due diligence and if they don't do it properly then the CQC will pick it up at inspection."

- 8.8 Other NHS leaders disagreed which suggests a difference in view in the sector. Amanda Oates, Executive Director of Workforce at Merseycare NHS Foundation Trust told us:

"What happens is that someone leaves under a cloud, they can pop up elsewhere and information about them can be lost. A centralised system would give a chance of their history going with them. It would give a level off scrutiny across the whole system. It would also ensure new recruiting organisations have transparent information during the recruitment process and also offer appropriate development or support if needed."

- 8.9 Although these views are clearly validly held by NHS Providers, we do not accept that they accurately represent the true picture.
- 8.10 Trusts are largely reliant upon the information provided to them by the applicant for the directorial position.
- 8.11 Although a Trust may have reasonably good information in relation to one of its own employees i.e. those stepping up to the Board role, they still may know little about that individual's background before arriving at the Trust; if the Trust is not proactive in training for the Board role, Board development and appraisals, it may

know little about how well (objectively) that individual has performed their function either previously or once they have been appointed director.

- 8.12 The position is even less clear in relation to those coming from outside the Trust. There may be ‘soft information’ (by which we mean common knowledge of reputation in the system) of varying degrees of quality and accuracy; the CV may have a full description of previous roles or may not; there should be a full explanation of gaps in the employment history⁵⁶ but these will be couched by the applicant and rarely fully tested; if the applicant has left a Trust with a settlement agreement the references may be extremely limited in quality and value.
- 8.13 The faith that the CQC will pick up where a Trust has failed in its due diligence is, with respect, misplaced. The CQC will explore systems and documentation, but we do not accept that the CQC is able to fill in the gaps in due diligence in relation to exploring a director’s background where a Trust has not done so or undertake such an investigation.
- 8.14 In challenging the need for a database we were posed the question:
- “Do you think the NHS leadership cadre is worse than local authorities or in the prison service? The cadre is of an equal quality. As a class, the Boards are just as capable as equivalent public service governance groups in other places”
- 8.15 That comment did not fill us with a similar degree of optimism.
- 8.16 We were much more convinced by the importance placed upon ensuring that where people have made honest mistakes and had to leave a particular Trust, that should not be a bar to them returning to the service once rehabilitated by training and support. They should not be barred by previous failure and it was stressed that there was an important difference between ‘incompetence’ and bad behaviour. We fully accept that, and we have striven hard to find the right balance. This is further discussed in [Chapter 9](#). But in our view the information retained about that individual should include both successes and failures.
- 8.17 We have tried to ensure we do not place onerous requirements upon Trusts but the information which we suggest should be supplied to a central database holder (see below), is all information which any ‘Well-Led’ Trust should have readily available to it. This would be information such as: the current job description; a full employment history with explanation of gaps⁵⁷; qualifications and any relevant

⁵⁶ This would not apply to gaps that are the result of any protected characteristic pursuant to the Equality Act 2010.

⁵⁷ Gaps that are because of a protected characteristic pursuant to the Equality Act 2010 would not need to be explained.

courses undertaken; full references; appraisals; upheld grievance and disciplinary findings. The database should also hold information about any criminal records checks, DBS checks⁵⁸ as well as any information about any NHS Protect investigations as well as fitness checks for Directors with both Companies House and the Charities Commission.

- 8.18 This is all information necessary to give a picture of the director concerned and employers and prospective employers ought to be able to access this information with ease. A central database would help to build the available picture and we believe would become a valuable resource to NHSI and to Trusts. The information held should be protected from Freedom of Information requests but should be accessible under a Data Subject Access Request by the individual to whom the records relate.
- 8.19 We have considered various organisations which could hold such a database but the most obvious place is within the NHSI who have indicated a willingness to do so. We have already prefaced this in [Chapter 5 – NHSI](#).

Settlement agreements

- 8.20 Settlement agreements are fortunately or unfortunately very much part of the fabric of the NHS and are difficult to shift. We heard mixed views and were encouraged by some to make another attempt to ban them within the NHS. We do not think that would be right as there are many circumstances where for one reason or another, an individual ought to move on from a particular employment and a formal disciplinary hearing is inappropriate. It is right to say that a settlement agreement is sometimes used in order to avoid inevitable disciplinary proceedings, but we would hope that is much rarer than other legitimate reasons.
- 8.21 The real issue with settlement agreements however, is not necessarily the agreement itself, but the agreement as to the nature of the reference that follows the director out of one employment and into another. A settlement agreement ought not to be able to prevent a reference from being full, open and honest.

References

- 8.22 It was the almost unanimous view of the IPs that there should be mandatory, good quality full and honest references in order to confront the continuing issue of settlement agreements enabling the problem of bad directors moving from Trust to Trust (the revolving door). The difficulty arises where the settlement agreement contains a confidentiality clause and an agreed 'vanilla reference'. We were told

⁵⁸ Currently a DBS enhanced with barred list check is only available for those directors who carry out a regulated activity. Legislation will be required to extend the check to all directors.

that there needs to be proper information sharing from the old employer to the new employer. Currently, too often that is not happening and the reason on occasion is the existence of a settlement agreement with an agreed reference as part of it. There was an almost universal view that this is a debilitating system and not conducive to good information sharing about both good and problematic directors.

- 8.23 The solution it seemed to us was not to seek once again to ban settlement agreements, but to seek to prohibit 'vanilla' references which may paint a misleading picture by omission.
- 8.24 We were told by one newly appointed senior CEO of her experience of discovering material in her hospital's files about an outgoing director who had moved to another Trust. The material had not been passed on to the next employing Trust and would have had significant relevance to whether that director could be regarded as being a fit and proper person. None of the information had been revealed in the reference which went with the director concerned.
- 8.25 Another Trust employed a senior director in a post when there was a current fraud investigation into that director which the new employing Trust knew nothing about and which had not been revealed by the NHS counter fraud body or by the previous Trust.
- 8.26 These stories, although we hope rare, are plainly not unique and arise directly or indirectly from a simple lack of accurate and full information being passed between Trusts and other NHS bodies. This is a problem which needs to be addressed.
- 8.27 In order to confront the continuing issue of settlement agreements and 'shifting people to another Trust' we recommend that all references must meet specific criteria designed to penetrate below the surface of the 'vanilla reference'. The criteria must be designed to include questions which will flush out and disclose previous wrongdoing and patterns of poor behaviour, or whether or not a person would have faced an inquiry or disciplinary process had they not left the Trust.
- 8.28 This approach is already taken in the financial services industry and the FCA have now created a mandatory reference scheme. This should not be beyond the NHS. A number of the issues the FCA had to confront would no doubt be similar to those issues that a similar scheme within the NHS would be faced with. The FCA published their guidance in September 2016 part of which we reproduce below:

"Scope of application: We think it is important for banks and insurers to seek references from all previous employers in the last six years, irrespective of the firm type or their regulated status. Any FCA- authorised firm is already required to respond to such requests, albeit in a different form. Removing this requirement would limit the exchange

of information between financial services firms and impede the ability of banks and insurers to conduct robust fit and proper assessments on their employees. References from non-financial services firms are likely to be general employment references; however, these can still provide important information to the hiring firm.

Obtaining references from overseas firms we note the comments regarding the potential difficulty in obtaining references from overseas employers, or non-financial services firms more generally. However, we highlight that the obligation on the requesting firms **is to take reasonable steps to obtain a reference**.

We believe it is the responsibility of each firm to judge what constitutes reasonable steps in the context of the circumstances of a case (and, where necessary, discuss this with the FCA as part of the authorisations process). Given this challenge, we have not prescribed what 'reasonable steps' means in the context of obtaining a reference as it is likely to vary, making any definition impractical to apply. However, we have added guidance to say that we expect that regulated firms providing a reference should normally be able to do so within six weeks."

8.29 The essence of the mandatory reference requires that:

- A firm should ... provide as complete a picture of an employee's conduct record as possible to new employers.
- A firm supplying a reference ... owes a duty under the general law to its former employee and the recipient firm to exercise due skill and care in the preparation of the reference.
- The firm may give frank and honest views, but only after taking reasonable care both as to factual content, and as to the opinions expressed.
- References should be true, accurate, fair and based on documented fact.
- Fairness will normally require a firm to have given an employee an opportunity to comment on information in a reference. The firm might do this through, for example, disciplinary proceedings.

A REVIEW OF THE FIT AND PROPER PERSON TEST

- 8.30 We recognise the potential difficulty which may arise for NHS organisations recruiting from outside the NHS or from abroad, but we see no reason why the recruiter should not take all reasonable steps to obtain the necessary information set out in the required criteria below. When recruiting from within the NHS there should be an absolute obligation to provide a compliant reference.
- 8.31 Amanda Oates, Executive Director of Workforce at Merseycare NHS Foundation Trust told us:
- "If you are negotiating with staff (over a compromise agreement) it would be helpful to be able to say to the employee, the regulator will not agree to a non-specific reference. That is very easy to say."
- 8.32 Apart from obvious basic information the template should require information concerning **proven** failures of management, dishonesty, bullying and harassment in the form of upheld grievances, upheld whistleblowing complaints, upheld complaints under any of the Trusts' policies and procedures and any upheld disciplinary proceedings and disciplinary sanctions, as well as whether any inquiry, investigation or disciplinary action would or may have taken place had the individual remained.
- 8.33 We recommend that full, honest and accurate mandatory references should be required from any employer in relation to any director covered by Regulation 5 to an NHS employer appointing an individual into a director-level position within the health system (whether public or in the independent sector). The mandatory nature of the reference means that it would not be possible to agree to confidentiality clauses in the context of a settlement agreement or other form of alternative dispute resolution.
- 8.34 In order to ensure compliance we will recommend that as part of the CQC 'Well-Led' inspections, a review of references, both those provided by Trusts and those received by them, should be part of the inspection process. The 'Well-Led' review should assess the quality of the references and, in particular, whether the references provided and received have met the mandatory criteria. A failure to comply with the mandatory reference requirements will lead to fault finding by the CQC and potential referral of the author of the reference to the HDSC.
- 8.35 In order further to ensure compliance we will recommend that every director level mandatory reference should be signed off by a Board director or a director covered by regulation 5. Deliberate withholding relevant information would fall to be considered as 'serious misconduct' (see [Chapter 9](#)).

- 8.36 The director involved should clearly have the ability to challenge what he or she regards as an unfair reference or element of it. There should be the facility to allow a note to be attached to the reference of any such objection and the reasons for it.

Power of CQC to require information from service providers and others

- 8.37 The CQC has a general power to require “information, documents, records (including personal and medical records)” which the CQC considers “necessary or expedient to have for the purposes of any of its regulatory functions” pursuant to S.64(1) of the HSCA and by virtue of S.64(3) HSCA this provision includes, in respect of information, documents and records kept via a computer, a power to require the provision of information, documents or records in legible form. The bodies from whom the CQC can require such information are contained in S.64(2) and include all NHS bodies and commissioners.
- 8.38 The 2014 Regulations also impose an obligation on the Service Providers to supply the categories of information set out in Schedule 3 to be supplied to the CQC. The most relevant for our purposes is paragraphs 4 and 7 of Schedule 3 (highlighted in bold below) which are “satisfactory evidence of conduct in previous employment relating to health or social care or children and vulnerable adults” (paragraph 4) and “a full employment history, together with a satisfactory written explanation of any gaps” (paragraph 7).
- 8.39 The mechanism for this is set out in **Regulation 5(5)** of the 2014 Regulations which provides (so far as is material):

The following information must be supplied to the Commission in relation to each individual who holds an office or position referred to in paragraph 2(a)⁵⁹ or (b)⁶⁰

- a) the information specified in Schedule 3, and
- b) such other information as is required to be kept by the service provider⁶¹ under any enactment which is relevant to that individual.

⁵⁹ That is, pursuant to Regulation 2(a) a “*director of the service provider*”

⁶⁰ That is, pursuant to Regulation 2(b), someone “*performing the functions of, or functions equivalent or similar to the functions of ... a director*”

⁶¹ A “*service provider*” is defined under Regulation 1 as “*in respect of a regulated activity, a person registered with the Commission under Chapter 2 of Part of the [Health and Social Care] Act [2008] as a service provider in respect of that activity.*”

- 8.40 Schedule 3 concerns ‘**Information required in respect of persons employed or appointed for the purposes of a regulated activity**’ and provides that the following information must be available to be supplied:
- Proof of identity including a recent photograph.
 - A criminal record certificate
 - Satisfactory evidence of conduct in previous employment concerned with the provision of services relating to—
 - a) health or social care, or**
 - b) children or vulnerable adults.**
 - Where a person (P) has been previously employed in a position whose duties involved work with children or vulnerable adults, satisfactory verification, so far as reasonably practicable, of the reason why P's employment in that position ended.
 - In so far as it is reasonably practicable to obtain, satisfactory documentary evidence of any qualification relevant to the duties for which the person is employed or appointed to perform.
 - A full employment history, together with a satisfactory written explanation of any gaps in employment
 - Satisfactory information about any physical or mental health conditions which are relevant to the person's capability, after reasonable adjustments are made, to properly perform tasks which are intrinsic to their employment or appointment for the purposes of the regulated activity.”
- 8.41 We recommend that to this list should be added the mandatory references referred to above, as well as information about appraisals that the director has undergone, and any information about grievance, disciplinary and employment tribunal findings.
- 8.42 Thus, information about each director, now enhanced, should not simply be available to the CQC but held by a central database holder to ensure consistency of information about each director and easy access to those who need it.

Conclusions and recommendations

- 8.43 We believe that a central database should considerably enhance the system of information retention in relation to senior executives within the health service and that such a database would be a valuable resource. We do not believe that the provision of the information to the central database holder ought to be overly onerous, as the majority of the information required should already be held in all Trusts' records.
- 8.44 We recommend therefore that a body (such as NHSI) (hereafter referred to as the Central Database Holder) creates and retains a database which will hold information about each director (including NEDs) to be accessible to potential employers, the NHSI and CQC and where necessary the HDSC ([see Chapter 9](#)). This could be held in any part of the NHSI system but could be held in the 'NHSI Directors' Database' ([Recommendation 2](#)). We recommend that, until legislation is passed, the CQC should amend its Guidance to include a recommendation that all Trusts should submit the relevant material to the Central Database Holder and whether or not they have done so should be assessed at the CQC's 'Well-Led' review. Until this is placed on a statutory footing the permission of each director to hold such data in the form suggested, would we understand be necessary.
- 8.45 Further we recommend the introduction of references containing mandatory information which cannot be curtailed by the terms of a settlement agreement ([Recommendation 3](#)).
- 8.46 The content of such mandatory references is to be designed by the NHSI in collaboration with other relevant organisations. We will leave it to others to fine tune the content of the mandatory reference but our suggested starting point is at [Appendix 3](#).

9. A power to disqualify

A power to disqualify directors guilty of serious misconduct

- 9.1 As we have set out in the introduction, the FPPT is widely perceived to be ineffective to prevent the revolving door syndrome and our view is that perception is accurate to the extent that there is no power to disbar directors in the 2014 Regulations.
- 9.2 Under the current regime there is no effective system for preventing directors, even after findings of serious misconduct have been made, from moving to another post within the service or moving prior to disciplinary proceedings taking place.
- 9.3 It is our view that certain behaviour by directors, namely “**Serious Misconduct**” should lead to consideration, by an independent service, of temporary or permanent disbarment from the post of director. What constitutes Serious Misconduct is set out in more detail below.
- 9.4 In order to make this effective, an organisation will need to be set up to inquire into allegations of serious misconduct and, where serious misconduct is found, to disqualify/disbar the individual. Such a service:
- (a) Has to be independent of the employing provider;
 - (b) could lie within NHSI;
 - (c) should be independent of the DHSC; and
 - (d) should have powers to investigate, determine and sanction the individual.
- 9.5 We suggest this service should have a title appropriate to its function and could be called the Health Directors’ Standards Council (provisionally referred to as the ‘HDSC’). There should be a power of appeal against findings and sanctions imposed by the HDSC to the Health, Education and Social Care Chamber of the First Tier Tribunal.
- 9.6 It is important to distinguish between the less than competent, who can with support and training be assisted to become competent, from the dishonourable, reckless and unscrupulous, and those who carry out acts of misconduct deliberately. The first category should in our view be dealt with at the employer level and will be assisted by the setting down of clear required competencies. The

latter should, at first instance be dealt with by the employer but, where a complaint relating to one of the categories of Serious Misconduct is upheld at that level, the employer should be required to refer the director concerned to the HDSC.

- 9.7 There are obviously reasons why there should ultimately be the ability to bar directors guilty of Serious Misconduct. The importance of having that sanction is to demonstrate that something can be done and that the badly-behaved director will not get away 'scot free'. We were told that one of the main issues around bullying was the lack of confidence that anything would happen:

“Knowing that there was a sanction like that (disbarment) would go a long way to end the culture of silence. It is a patient safety issue, people subject to bullying and harassment, their cognitive function declines by 60%”⁶². (Please see [Chapter 10](#) for further examples).

- 9.8 The members of Parliament to whom we spoke each had stories to tell of poor practices including misconduct among directors of health Trusts and the apparent lack of power to take effective action against them. There was considerable frustration that the revolving door appears to have kept on revolving and the lack of action to stop it. Further discussion of the problems which have arisen particularly with whistleblowers, bullying and harassment can be found in [Chapter 10](#).

- 9.9 A specific example was given by a number of IPs in relation to one Trust director accused of bullying and intimidation. There were further allegations of financial impropriety and suppression of whistleblowing. The director moved to a senior directorial position in another NHS Trust which found him to be a Fit and Proper person. Whether this was due to a lack of accurate information being provided to that Trust, or a lack of appropriate investigation or some other reason, it would seem clear that allegations of such conduct ought to have been carefully reviewed by an independent body. On one view, not only should this person not have been able to move to another directorial role as he did, but there were allegations that more than one red line had been crossed and an investigation of serious misconduct ought to have been undertaken.

- 9.10 There was further concern expressed that cases drawn to the attention of the relevant departments of government were either not pursued, or there was no information forthcoming as to what investigation had taken place even in cases involving allegations of fraud.

- 9.11 Further, there has to be provision for other routes of referral by regulators and by individuals where there is complaint that the employer has not dealt appropriately

⁶² Dr Anthea Mowat BMA Rep Chair

with the issues raised. There was a sense of powerlessness, even among the MPs to whom we spoke, to take appropriate action. If the employing Trust would not act, who would?

9.12 We envisage that the system and professional regulators (including but not limited to) CQC, GMC, NMC, GDC, HCPC, PSA, NGO and DHSC should all have powers of referral to the HDSC. Individual complainants ought also to be able to refer to the HDSC but where there has been no prior investigation by the Trust concerned, the HDSC's first route of investigation ought always to be to refer to the employer unless there is very good reason not to do so or unless the director concerned has moved to a new Trust or outside the jurisdiction.

9.13 Although all referrals which have not previously been considered by a Trust disciplinary process should where possible, and provided the individual is still employed at the Trust where the misbehaviour is said to have occurred, be referred to the Trust employer. There will be instances where the HDSC will be the first body to consider such allegations. We envisage this may occur in the following circumstances:

- (a) Where the director has left the relevant Trust where the misbehaviour is alleged to have occurred and is not currently working;
- (b) Where the director has gone to work elsewhere or has moved outside the English jurisdiction;
- (c) Where there is good reason for believing that the employing Trust is not capable or willing to undertake an independent investigation. We hope this would be exceptionally rare.

9.14 Where the HDSC is the first body to consider an allegation of Serious Misconduct by a director, referred by an individual, there should in our view be the power to sift complaints which have no reasonable prospect of a finding of Serious Misconduct. Where a referral has been made by another responsible regulator or responsible body as referred to above, every such referral should be fully investigated.

9.15 It is our view that allegations made in referrals by individuals would need to pass a sift test, namely, a reasonable prospect test. This is to counter the danger of vexatious or unfounded complaints tying up a director in an unfair way. Although many complaints are valid and genuinely made, there is a category of vexatious or unfounded complaint from which directors should be protected. By a reasonable prospect test we mean, applying the civil standard of proof - is there a reasonable prospect of a finding of 'Serious Misconduct' being made?

- 9.16 The HDSC must have powers to investigate, and similar to those powers currently held by the CQC, to require the provision of information and documentation from the individual director and from the relevant Trust. This is an important power given that on rare occasions it is the Trust itself which proves uncooperative with an investigation. Failure to respond to or assist a HDSC inquiry would itself be capable of leading to sanction of the directors responsible and potentially to criminal sanctions as presently provided under Section 64 of the HSCA 2008.

Definition of serious misconduct

- 9.17 There was a consensus amongst the information providers that certain behaviours clearly fell into a category of conduct which crossed the red line between ineffective or poor management and deliberate misconduct.
- 9.18 Some Serious Misconduct is already incorporated in the regulation (under Part 2 of Schedule 4) which lists inclusion on the DBS list and bankruptcy.
- 9.19 The establishment of the category of Serious Misconduct as potentially disbarable behaviour is not intended to be used to disbar the 'incompetent' individual, or where an individual is deemed to have failed in his or her function through no lack of effort, who might be rehabilitated with support and training.
- 9.20 Whilst it will be for others to give what constitutes serious misconduct further consideration and define it more closely, it seemed to us that Serious Misconduct should include such issues as:
- (a) Criminal convictions for offences leading to a sentence of imprisonment or otherwise incompatible with service in the NHS;
 - (b) Dishonesty;
 - (c) Deliberate bullying;
 - (d) Deliberate discrimination, harassment or victimisation;
 - (e) Sexual harassment as defined in the EA;
 - (f) Victimisation or knowingly allowing the victimisation of: whistleblowers; those raising concerns with the Freedom to Speak Up Guardian; or those complying with the duty of candour;
 - (g) Causing, facilitating, colluding in, or requiring any staff member to fail to comply with the duty of candour including by means of a settlement or confidentiality agreement;

- (h) Causing, facilitating or colluding in the reckless mismanagement of an organisation resulting in the compromise of patient safety;
- (i) Falsification, concealment or suppression of records, data or other information which is required to be provided to any other person or organisation;
- (j) Encouraging, facilitating or colluding in the falsification, concealment or suppression of records, data; or other information which is required to be provided to any other person or organisation;
- (k) Encouraging, facilitating, or colluding in the provision of false or misleading records, data or other information which is required to be provided to any other person or organisation;
- (l) Without reasonable excuse failing to provide records, data, information or evidence to legitimate statutory or government directed inquiries, reviews or investigations;
- (m) Without reasonable excuse failure to provide records, data, information or evidence to the CQC or NHSI when requested to do so.

Serious Criminal Convictions

9.21 It is obvious that a serious criminal conviction is Serious Misconduct and should be disbarable conduct. The problem is to identify what is 'serious'. On one view, any criminal conviction is. But that is, in our view, to take too rigid an approach and we do not think that chimes sufficiently with the importance of remediation and rehabilitation. Our view is, therefore, that not all criminal convictions should fall into the category of Serious Misconduct but only those where the behaviour involved is deemed incompatible with service in the NHS or where the conviction has led to a sentence of imprisonment. Thus, a historic, previous conviction for shoplifting which did not result in imprisonment, for example, would not automatically fall into that category.

Dishonesty

9.22 Behaviour involving deceit or dishonesty whether or not causing financial loss, is clearly capable of being Serious Misconduct and should lead to consideration of disbarment. Although it is tempting to say 'any dishonesty at any time' is a red line not to be crossed, for reasons mentioned above, low level dishonesty many years previously ought not necessarily to lead to disbarment.

Deliberate Bullying and Harassment

- 9.23 The problem with bullying is that it can often be an unarticulated ‘known’: people often know **who** the bully is but they find it more difficult to define **what** the bullying behaviours are. The evidence of bullying is often only the victim’s subjective perception of events and, is, therefore easy to dismiss. Further, although there may be obvious cases, such as openly aggressive, humiliating or insulting behaviours, bullying also often manifests in covert, subtle ways which makes it difficult to identify.
- 9.24 There is no legal definition of bullying. ACAS defines bullying as:
- “Offensive, intimidating, malicious or insulting behaviour, an abuse or misuse of power through means that undermine, humiliate, denigrate or injure the recipient.”
- 9.25 Although bullying is not specifically prohibited by any statutory enactment, if the employer fails to resolve it, such a failure may destroy the implied term of trust and confidence between employer and employee and may constitute constructive unfair dismissal.
- 9.26 There is a legal definition of harassment in S.26 of the Equality Act 2010 (hereafter referred to as the “EA”). There are two types of harassment: unwanted conduct which has the purpose or effect of violating the victim’s dignity on the one hand and unwanted conduct which has the purpose or effect of creating an **‘intimidating, hostile, degrading, humiliating or offensive environment’** on the other (referred to hereafter as a “hostile” environment). This definition deals with the subjectivity problem by, firstly, expressly including the victim’s perception as partly determinative of the issue and, secondly, by introducing an element of objectivity into the test. So, the EA definition states that when assessing whether the unwanted conduct has the prohibited effects of violating dignity or creating a hostile environment, the victim’s perception (which is necessarily subjective) must be taken into account but this must be filtered through a lens of objectivity, namely whether it is **‘reasonable for the conduct to have that effect’**.
- 9.27 The legal definition of “sexual harassment” is also contained in S.26 of the Equality Act 2010 and is the same definition as “harassment” except that the unwanted conduct is specified to be of a sexual nature.
- 9.28 Many IPs have raised the issue that bullying and harassment often exist in the ‘grey area’ of conduct which can easily be dismissed as ‘banter’ or ‘robust’ management. What complicates things further is that cultural and societal norms about behaviour may change over time. The rise of ‘me too’ has highlighted the

cultural debate about what is, and what is not, acceptable behaviour. Examples of unacceptable behaviour suggested by ACAS include:

- Spreading malicious rumours, or insulting someone by word or behaviour
- Copying memos that are critical about someone to others who do not need to know
- Ridiculing or demeaning someone – picking on them or setting them up to fail
- Exclusion or victimisation
- Unfair treatment
- Overbearing supervision or other misuse of power or position
- Unwelcome sexual advances – touching, standing too close, display of offensive materials, asking for sexual favours, making decisions on the basis of sexual advances being accepted or rejected
- Making threats or comments about job security without foundation
- Deliberately undermining a competent worker by overloading and constant criticism
- Preventing individuals progressing by blocking promotion or training opportunities

9.29 Bullying and harassment have an impact on patient care. The GMC has pointed out that:

“Bullying and undermining are completely unacceptable and can have a big impact on the safety of care given to patients.”

9.30 Victims of bullying are significantly more likely to be unable to think clearly and are more likely to make errors. Disrespectful behaviour and poor communication between colleagues is likely to be mirrored in how patients are treated too.

9.31 The BMA’s evidence is that approximately one in five doctors in the NHS say they have been bullied or harassed by managers or other staff in the past year and the BMA has recently launched a programme to raise awareness of workplace

bullying and harassment. The BMA's examples of bullying or harassing behaviours are:

- Physical or verbal abuse that directly attacks or ridicules a colleague;
- Inappropriately criticising or humiliating a colleague in front of patients or colleagues;
- Regularly ignoring a colleague and excluding them from meetings or events;
- Making derogatory comments or offensive jokes about women, disabled people or people of a particular race or faith background, sexual orientation or age;
- Inappropriate touching, sexualised comments or trying to elicit sexual favours through threats or promises;
- Using threats (e.g. about job security or patient care) to get someone to comply with work demands;
- Setting someone up to fail by overloading them, giving inadequate support and blaming them for failure afterwards;
- Constant criticism, excessive scrutiny and micro management of tasks.

9.32 The BMA distinguishes between performance management and bullying in the following ways:

Performance management is:

- Clearly communicating expectations in advance
- Applying performance standards fairly and consistently
- Discussing performance issues privately with relevant members of staff
- Giving constructive feedback and setting out necessary steps for improvement
- A willingness to listen and understand what may lie behind performance problems

- Providing appropriate support and opportunities to improve before taking further action

Performance management is not:

- Constantly changing the goal posts
- Being inconsistent in dealing with performance issues or showing favouritism
- Criticising, humiliating or undermining staff in public
- Jumping to conclusions and seeking to blame others for failures
- Immediately threatening or taking disciplinary action without first offering appropriate support and a chance to improve

9.33 Our view is that, in order to constitute Serious Misconduct, there must be a mental element to the conduct. To put it another way, the bullying must either be of a nature that the effect of it must be obvious to the perpetrator in order for it to be sanctionable or the individual must have been formally warned about his or her conduct but nevertheless persisted.

9.34 Bullying and harassment will normally be regarded as ‘Gross Misconduct’ in the Trust’s disciplinary policies. We regard this as Serious Misconduct which, when found and upheld by a Trust-based disciplinary process, should lead to a referral to the HDSC.

9.35 Whistleblowing is dealt with in further detail in ([Chapter 10](#)). A Trust acts unlawfully if the reason or principal reason for dismissing a worker is that the worker has blown the whistle (also known as ‘making a protected disclosure’) or if the worker is subjected to a detriment on the ground that he or she has blown the whistle. We regard this as Serious Misconduct by any director who has been part of that decision-making process which, when found and upheld by a Trust-based disciplinary process, should lead to a referral to the HDSC.

Victimisation

9.36 We also regard the victimisation of those who have raised concerns with the Freedom to Speak Up Guardian and those who are complying with the duty of candour to be equally worthy of constituting ‘Serious Misconduct’ because of the importance of Speaking Up and Candour in the context of patient care. We suggest that a suitable definition might be:

'Victimisation or knowingly allowing the victimisation of whistleblowers; those raising concerns with the Freedom to Speak Up Guardian; or those complying with the duty of candour.'

Reckless mismanagement which compromises patient safety

9.37 Our initial view was that there should be a clear distinction between the incompetent, who can be remediated, and those who are guilty of Serious Misconduct. We consider that only the latter should be subject to potential disbarment. However, we were persuaded by some of the IPs that there is a category of mismanagement which falls into Serious Misconduct territory, which we would define as reckless mismanagement which has the effect of compromising patient safety. This would seem to capture the sort of mismanagement which has historically led to some of the better known systemic failures in the health service.

9.38 The reason for our initial reluctance to venture into the issue of mismanagement was because we did not consider that the CQC's definition of mismanagement was clear enough and were not sure we could improve upon it.

9.39 The CQC's definition is:

"Mismanagement" means being involved in the management of an organisation or part of an organisation in such a way that the quality of decision making and actions of the managers falls below any reasonable standard of competent management".

9.40 The CQC gives the following examples that may amount to 'mismanagement':

- Transmitting to a public authority, or any other person, inaccurate information without taking reasonably competent steps to ensure it was correct.
- Failing to interpret data in an appropriate way.
- Suppressing reports where the findings may be compromising for the organisation.
- Failing to have an effective system in place to protect staff who have raised concerns.
- Failing to learn from incidents, complaints and when things go wrong.

- Failing to model and promote standards of behaviour expected of those in public life, including protecting personal reputation, or the interests of another individual, over the interests of people who use a service, staff or the public.
- Failing to implement quality, safety and/or process improvements in a timely way, where there are recommendations or where the need is obvious.

9.41 All of these may be suitable examples of various forms of mismanagement but in order for mismanagement to reach the level of serious misconduct that might lead to disbarment, it seems to us that the degree of mismanagement has to be both reckless and result in the compromise of patient safety.

Falsification of records/ Failing to provide records

9.42 Further, there is real concern in the service about those who falsify or seek to conceal relevant information from regulators and investigators. In our view, any behaviour which does so, or colludes or requires others to do so should be regarded as Serious Misconduct.

9.43 Those categories of behaviour which are calculated to undermine the power to investigate and fundamentally undermine the duty of candour ought to be regarded as 'red line' behaviour referable to the HDSC.

Requirement for the Provision of Information

9.44 We consider that it is of particular importance that Trusts cooperate with the CQC and NHSI in the provision of information when requested to do so. Our view is that this is consistent with the duty of candour and will ensure transparency.

9.45 The CQC already has powers to require the production of information from providers under S64 HSCA.

9.46 There have been several, well-known cases, publicised in the press, about the problem of the 'revolving door': the ability of directors who have behaved badly in one Trust to hide in plain sight by moving from Trust to Trust (sometimes via an ALB) unchallenged.

9.47 We consider that those directors' movements around the system have been enabled by both the lack of information held about them and the failure of Trusts to share such information or to be proactive in finding it out. The need for a central database and for mandatory, adequate references is dealt with in [Chapter 8](#).

- 9.48 Whilst we do not make any determination about directors' conduct in individual cases, it is notable that there have been a number of cases which have generated local and national publicity and have caused public disquiet.
- 9.49 Our recommendations in relation to mandatory references and an independent disbarring service are intended to prevent those proved to have been guilty of misconduct moving around the NHS system.

A sanction regime

- 9.50 Although some Serious Misconduct may deserve a sanction of 'permanent disbarment' it is not possible to envisage now all the circumstances which might arise and which will need to be taken into account. We suggest therefore that disbarment itself ought either to be for a period of months, years or permanent. We do not envisage that it could ever be appropriate to impose conditions following a finding of Serious Misconduct but the HDSC would be able to make recommendations where appropriate to rehabilitate an errant director.
- 9.51 We cannot see any alternative to providing the HDSC with the power to impose an interim suspension from directorial posts during a period of investigation where there is otherwise a significant risk of public harm or to adopt the GMC guidance:

'For the protection of members of the public or it is otherwise desirable in the public interest to maintain public confidence and uphold proper standards of conduct and behaviour.'

A time limit

- 9.52 In our view there should be a temporal limit on the conduct which can be examined by the HDSC. This is for the practical reason that very old allegations are very difficult to investigate and sometimes even harder to defend. We appreciate that some will have very strong views that some conduct should be investigated however long ago it happened, and exceptionally that might be the case, but the general rule in both civil and regulatory law is that complaints about historic misconduct are time limited.
- 9.53 There are a number of legal precedent time limits which could be adopted:
- (a) Contract law allows 6 years from the date of the breach of contract for proceedings to be commenced;
 - (b) Personal Injury allows three years from the date of the injury or the date of knowledge of the injury; or

(c) Employment Tribunals allow three months from the date of the act complained of.

9.54 In regulatory proceedings against doctors, the GMC apply what is known as the 'five year rule'.

9.55 Rule 4 (5) of the GMC Fitness to Practise Rules provides as follows:

"No allegation shall proceed further if, at the time it is first made or first comes to the attention of the General Council, more than five years have elapsed since the most recent events giving rise to the allegation, unless the Registrar considers that it is in the public interest, in the exceptional circumstances of the case, for it to proceed."

9.56 In our view there is good reason to replicate that time period for the purposes of bringing complaints to the HDSC. One of the central issues which has repeatedly been raised by our IPs is the unfairness of the distinction between registered doctors who sit as directors and their non-qualified co-directors. One of the purposes of the changes we are proposing is to provide parity as far as is appropriate and relevant between all directors whether they are 'medical' or non-medical.

9.57 We suggest therefore that the period to be imposed ought to be five years from the most recent events giving rise to the allegations with a power to consider older events if that is regarded as being necessary in the public interest if there are exceptional circumstances.

The HDSC

9.58 It is not for us to design the form of the panel which would have power to call for evidence and documents, investigate and consider the complaints made. However, the panel must be independent and in line with modern regulatory proceedings it would be sensible to consider requiring the chair to be legally qualified.

Conclusion and recommendations

9.59 The line between less than competent and Serious Misconduct must be carefully drawn so as not to exacerbate the existing problem that there is a shallow pool of people who want to be directors. Our view is that we must be careful not to do something which has the consequence of making director roles appear even less attractive and even more difficult because that will ensure that the pool of people willing to undertake those roles becomes even shallower. Having a clear definition of what is unacceptable and sanctionable ought to help to reassure those who are striving to perform properly and well but failing.

A REVIEW OF THE FIT AND PROPER PERSON TEST

- 9.60 Consideration will have to be given to ensuring that the test is applied to independent healthcare providers. This can be done both by ensuring that anyone disbarred by the HDSC could not be regarded as a fit and proper person and secondly by ensuring that the NHS does not commission any services from an independent provider upon whose Board sits a disqualified director.
- 9.61 By recommending as we do that a disbarring service is established, it is not intended to diminish the importance or necessity of the FPPT. The FPPT will continue to be applied by relevant employers and where they fail to do so they will be subject to CQC censure. The disbarring service which we will recommend is intended to deal purely with those guilty of serious misconduct and to ensure that there is a power, as was originally intended, to remove those people from directorships and bar them. Primacy over issues of mismanagement are still to remain firmly with the Trust Board although the new requirements as to required competencies are designed to strengthen and improve the Board function.
- 9.62 We recommend ([Recommendation 5](#)) therefore that there should be created an organisation under the responsibility of the NHSI (potentially to be known as the 'Health Directors' Standards Council' (HDSC)) which will have the power to suspend and to disbar directors covered by Regulation 5 of the Regulations (referred to hereafter as Regulation 5), who are found to have committed Serious Misconduct.
- 9.63 We recommend that consideration be given to ensuring that the FPPT, as set out in Regulation 5, incorporates as Serious Misconduct the same issues as described in the test to be applied by the HDSC.

10. Settlement agreements and confidentiality clauses

What is a settlement agreement?

- 10.1 A settlement agreement is a written agreement, regulated by statute, where an employee agrees to waive his or her right to bring an employment tribunal claim against the employer usually in exchange for money and an agreement to keep the circumstances of the employee's departure, the amount of the settlement payment and sometimes the fact of the agreement itself, confidential. Secrecy about the details of the settlement agreement is commonly known as a 'gagging' clause and secrecy about the fact of the agreement itself is often referred to as a 'super gag'.
- 10.2 Almost all of the IPs felt uncomfortable about settlement agreements and the lack of transparency around them which they felt was incompatible with the principles of public life, expressed in the Nolan principles.

The problems with settlement agreements and the FPPT

- 10.3 Whilst a settlement agreement can be a useful way of circumventing a long and tortuous disciplinary or capability process with a difficult employee, the reality is that the gagging and super-gagging clauses prevent the flow of important information to future employers and may also 'hush up' 'red line' behaviour or Serious Misconduct that should render the individual unfit and unable to hold future senior positions.
- 10.4 Settlement agreements are not the only way that disputes can be resolved outside of the litigation process. Other forms of alternative dispute resolution include arbitration, mediation and judicial mediation. It is possible that confidentiality could be agreed as part of these methods of alternative dispute resolution and the problem of the resulting lack of transparency applies in these circumstances also.
- 10.5 The NGO has flagged problems regarding the use of confidentiality clauses within settlement agreements in the NHS. These clauses act as a further obstacle to speaking up about concerns at a time when a worker may be especially vulnerable.

10.6 One whistleblower told us:

"If the tragedies of mid staffs and Gosport are to be avoided, it is crucial that workers (NOT just those to whom PIDA applies) can speak up (NOT just [whistle blow]) whenever anything gets in the way of the delivery of great care."

10.7 Settlement agreements have been used not only to move senior directors on, where they can do harm elsewhere, but also to attempt to gag whistleblowers or those who have 'spoken up'.

10.8 Sir Robert Francis told us:

"My strong view is that there is no space for confidentiality agreements which have a chilling effect on communications between employers, employers and their regulators."

Whistleblowing

10.9 The informal term 'whistleblowing' is used to refer to the process of making a protected disclosure in accordance with Part IVA of the Employment Rights Act 1996 (ERA) and references in this report to 'whistleblowing' mean the process of making a protected disclosure in accordance with the ERA.

10.10 A settlement agreement is, by law, not able to prevent a worker from 'blowing the whistle' (referred to in the legislation as making a "protected disclosure") under S.43J of the ERA.

10.11 If a worker makes a "**protected disclosure**" then he or she receives protection from any subsequent retaliation from the employer in form of a detriment or a dismissal. A "**protected disclosure**" is defined under S.43B of the ERA as "**any disclosure of information**" which in the "**reasonable belief of the worker**" is "**made in the public interest**" and tends to show:

- a) that a criminal offence has been committed, is being committed or is likely to be committed,
- b) that a person has failed, is failing or is likely to fail to comply with any legal obligation to which he is subject,
- c) that a miscarriage of justice has occurred, is occurring or is likely to occur,

- d) that the health or safety of any individual has been, is being or is likely to be endangered,
- e) that the environment has been, is being or is likely to be damaged, or
- f) that information tending to show any matter falling within any one of the preceding paragraphs has been, is being or is likely to be deliberately concealed.

- 10.12 There has, however, been significant criticism of the actual level of protection given to whistleblowers in the NHS. The responsibility of gaining the protection afforded by the legislation falls on the individual. The process can be time-consuming and costly and, in an employment tribunal, the usual rule is that each side pays their costs and such costs can be prohibitive for an individual, particularly one employed by the public sector.
- 10.13 We received evidence from a number of individuals about the particular problems whistleblowers face in the NHS. We met with the National Guardian (Dr Henrietta Hughes), attended one of the NGO's Advisory Working Group meetings and, separately, had meetings with Dr Minh Alexander, Dr David Drew, Bernie Rochford, Clare Sardari and Mick Start. We also received a considerable amount of information from others including Sharmila Chowdury and Andrew Ward.
- 10.14 The relatively low levels of whistleblowing cases in the NHS suggests either that there is very good management practice in dealing with whistleblowing issues or that employees are, for some reason, reluctant to raise them. The NHS only received 39 [whistleblowing cases about Foundation Trusts](#) in 2013/2014, 28 in 2014/2015 and 60 in 2015/2016. Nationally, the figure for numbers of whistleblowing cases received by Employment Tribunals ranges between 1,395 and 2,754 (in the period between 2007/2008 and 2016/2017). Whilst the national figure for numbers of whistleblowing cases is not particularly high, the number of whistleblowing cases in the NHS is surprisingly low for such a large employer.
- 10.15 There have been a number of notable recent cases which highlight the difficulties that NHS whistleblowers face.
- 10.16 **In Sardari and Gates v Torbay & Southern Devon Health & Care Trust and South Devon Healthcare NHS Foundation Trust (South Devon) (Case Number: 1700084/2013)**, the claimants were found by the Exeter Employment Tribunal to have suffered whistleblowing detriments after they made a protected disclosure that Dr Vasco-Knight (then Chief Executive of South Devon Trust) failed to comply with legal obligations (such as the possible breach of the equality provisions for public bodies, possible breach of employment policies and fiduciary duties) when

she failed to declare that the person appointed to a position in the Trust was her daughter's boyfriend. Not only that but the Tribunal Judgement was critical of the conduct of South Devon, stating that its conduct in **"suppressing the details"** of an investigation report and **"misleading the other parties as to its content"** was **"in bad faith"**. Further, the judgment was also critical of the Chairman of South Devon Trust, Peter Hildrew, citing part of his evidence as **"ludicrous"** and contrary to the contemporaneous documents, and criticising him for failing to disclose relevant letters and the investigation report to the claimants. Dr Vasco-Knight was also criticised because she treated the claimants' complaints as **"malicious and unfounded"**. South Devon's conduct led to compensation to the claimants of £228,778.10.

- 10.17 In **Marks v Derbyshire Healthcare Foundation Trust (Case Number: 2603606/2013)** the Nottingham Employment Tribunal upheld Mrs Marks' complaints of unfair dismissal and sexual harassment, holding that she had been sexually harassed by the Chair of the Trust (Mr Baines) and that Mr Baines and the Chief Executive (Professor Trenchard) had 'colluded' to force her out of her job. Not only that but the Trust's former Vice Chair (Mr Martin) was criticised for helping to cover up what had happened. The Tribunal stated:

"The other men in this case, which include Professor Trenchard, Mr Martin and Mr Hall (all senior executives) then assisted Mr Baines in covering this matter up and preventing any proper investigation into his behaviour. They allowed him to retire with his good name in tact because he is a man. They treated Mrs Marks in the way that they did because she is a woman."

- 10.18 Mrs Marks was awarded £832,000 in compensation.
- 10.19 It is clear that employees' concerns about the extremely poor standards of care at Liverpool Community NHS Trust (reported on by Dr Kirkup) were routinely ignored. Local MPs (Rosie Cooper MP and Frank Field MP) have articulated the difficulties faced by whistleblowers at the Trust and Rosie Cooper MP (who had herself witnessed staff being put under considerable pressure trying to deliver appropriate levels of care) raised questions about the management of the Trust with the Prime Minister and the Minister for Health in 2014.
- 10.20 Dr Kirkup's report identified, (at paragraph 1.15), that when staff at Liverpool tried to raise concerns or grievances as a result of being bullied, the response was **"seriously deficient"**. He heard repeated accounts of staff being suspended without being told why sometimes for many months without any apparent process for resolution. This contributed to a **"climate of fear and insecurity"** and understandably made staff reluctant to speak out about concerns over service failures and working conditions.

10.21 Whistleblowing and Speaking Up are important vehicles for the ventilation of concerns. Whistleblowing has however, a particular legal definition (the individual must make a protected disclosure) and is relatively narrowly defined. Speaking Up, on the other hand, covers a much wider category of concerns. The NGO illustrated the breadth of Speaking Up by giving us an example about a concern about a broken sink. The broken sink could simply be a facilities management issue or it could signify a wider issue with infection control, in which case it is a patient safety issue as well. The development of the Freedom to Speak Up Guardian role was a recommendation made by Sir Robert Francis in “**Freedom to Speak Up**” in 2015. The standard NHS contract requires all Trusts and Foundation Trusts to nominate a Freedom to Speak up Guardian.

10.22 Whistleblowing and Speaking Up are vital pathways to ensuring that patients are safe. There are 1.3 million employees employed by the NHS. The NGO has described them as ‘the eyes and ears’ of the NHS. She told us:

"The information that these employees carry is 100% of the information about the health service. The amount of information that a Chief Executive carries, on the other hand, is only a small percentage of this."

10.23 It is critical then that Whistleblowers and those who Speak Up are empowered to do so. The ability to blow the whistle or speak up depends to a great extent, in our view, on a culture that is receptive. Sir Robert Francis correctly pointed out, in “**Report of Mid Staffordshire NHS Foundation Trust Public Inquiry**” that:

“Whistleblowing is only necessary because of the absence of systems and a culture accepted by all staff which positively welcomes internal reporting of concerns. If that culture is absent then raising concerns external to the system is bound to be a difficult and challenging matter exposing the whistleblower to pressure from colleagues. Therefore, the solution lies in creating the right culture, not in focusing on improvements to whistleblowing legislation, important though such protection is⁶³”

10.24 Given the importance of the role of whistleblowing and Speaking Up in patient care, our view is that where directors regulated by regulation 5 are involved in the deliberate suppression of whistleblowing or the deliberate targeting or bullying of a whistleblower or anyone who speaks-up to the speaking up guardian, their behaviour should constitute Serious Misconduct (see [Chapter 9](#) for further details) and lead where appropriate to a sanction of disbarment.

⁶³ Paragraph 2.400 of “Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Volume 1.”

Overview and recommendations

- 10.25 By imposing the possibility of a severe sanction upon directors ([Recommendation 5](#)) who seek to suppress or conceal whistleblowing or speaking up, we hope to send a message, not simply that they risk their jobs at their current Trust, but that following investigation and review by the HDSC they may be disbarred from any directorial position within the health service.
- 10.26 By adding as a core competency an understanding of the importance of the information provided as a result of Speaking-Up and the duty of candour we hope to further underline the responsibilities of directors.
- 10.27 Further by imposing the requirement of a mandatory reference ([Recommendation 3](#)) we hope significantly to mitigate the silencing effect of settlement agreements in relation to directors who have committed Serious Misconduct.

11. What other regulators and organisations do

Introduction

11.1 In this section we have focused on the activities of other regulators (such as Ofsted, the FCA, the GMC, the PSA, the TRA, the GDC and the HCPC) and other organisations (such as the MOD) that are relevant to the issues of whether an individual is a fit and proper person and the retention of information.

Office For Standards In Education

11.2 We met with Helen Humphreys (Specialist Adviser, residential care), Dee Coleman (Principal Officer, early years), Andrew Wilson, Katy Kelly and Jane Woodcock (Regulatory Professionals).

11.3 Ofsted is the Office for Standards in Education, Children’s Services and Skills. It inspects and regulates services that care for children and young people, and services providing education and skills for learners of all ages.

11.4 Ofsted maintains two registers: the Early Years Register and the Childcare Register. Applicants must submit DBS (disclosure and barring service) checks with their application and Ofsted also undertakes other checks including a check of local authority children’s services department records. In some circumstances, including where Ofsted has identified a cause of concern, Ofsted carries out further checks and an interview. Should Ofsted decide to refuse registration, a ‘notice of intention to refuse’ will be sent to the applicant. If no response or objection is received within 14 days a ‘notice of decision to refuse registration’ will be issued (from which there is a right of appeal).

11.5 Ofsted houses an inspectorate with statutory powers. It has 400 directly employed inspectors who undertake inspections on a 4-yearly cycle. Part of the inspection regime is to assess for continued registration. Amongst Ofsted’s powers are powers to de-register the organisation and powers to take enforcement action against individual directors as well as the provider. Ofsted also has statutory powers of prosecution.

11.6 Ofsted applies a fitness test to its registered providers. The fitness test is similar to the FPPT except that it does not cover “qualifications, competence, skills and experience”. The method of applying the fitness test involves a process of considering an application form, contacting referees and holding a ‘fit person’

interview. Further, Ofsted inspects against the criterion of the effectiveness of leadership and management.

- 11.7 Ofsted has a sophisticated IT system called 'Cygnum' which retains full records about registered providers and registered persons. Ofsted keeps records of approximately 66,000 Early Years providers (of which around 25,000 are group providers and around 41,000 are individual child minders) and around 2,400 providers in the social care context.
- 11.8 Cygnum's records contain the following information about both registered providers and registered persons:
- (a) Registered providers: information about the provider's name, address, type, which local authority the provider works within, the provider's remit, the type of the last inspection, the date of the last inspection, the date the provider was approved, whether there have been any warnings and whether there are any 'special considerations';
 - (b) Registered persons: information about the person's name, address and contact details, where the individual is working, where they have worked in the last 5 years, what role they are currently undertaking, what their registration status is and whether there are any warnings.
- 11.9 Ofsted has the power to request that an application is withdrawn and is re-issued; the power to investigate the issue further; and/or the power to refuse registration. Where an application is refused that results in the individual being disqualified and, in that circumstance, the individual has to reapply and persuade Ofsted to waive the disqualification.

Financial Conduct Authority

- 11.10 We met with Richard Fox (Head of Cross-Sectoral & Funds Policy) and David Blunt (Head of Conduct Supervision).
- 11.11 The FCA regulates financial firms providing services to consumers and maintains the integrity of the UK's financial markets. It regulates 58,000 financial services firms and financial markets in the UK and is the prudential regulator for over 18,000 of those firms.
- 11.12 Under the Financial Services and Markets Act 2000 (FSMA), the FCA can prohibit any individual from performing a 'specified function'. In 2014 and 2015 prohibition orders were issued to 25 and 27 individuals respectively. The kinds of behaviour that have in the past resulted in prohibition have been: providing false or misleading information to the FCA (including information relating to identity, ability

to work in the UK and business arrangements); failing to disclose material considerations on application forms such as details of County Court Judgments, criminal convictions and dismissal from employment for regulatory or criminal breaches; serious acts of dishonesty (for example which may have resulted in financial crime); and serious lack of competence.

- 11.13 The FCA applies a statutory 'fit and proper person' test to assess whether individuals are suitable to perform a controlled function. When considering fitness and propriety the FCA assesses the individual's honesty, competence and capability and financial soundness. For senior positions, when assessing fitness and propriety, regard must be had to the individual's qualifications, competence, their personal characteristics and whether they have undergone training. The FCA may withdraw an approval where it considers that a person is not a fit and proper person to perform the relevant function.
- 11.14 Individuals must submit a detailed application to the FCA in order that their fitness and propriety can be assessed. The application form's fitness and propriety section asks questions of fact requiring a 'yes' or 'no' answer about particular actions. Some questions include the word 'ever', meaning that the required answers are not restricted to a specified period.
- 11.15 The FCA has mandatory requirements about regulatory references which came into force on 7 March 2017 (referred to in [Chapter 8](#)). Regulatory references must cover the past 6 years from current or previous employers including overseas employees. Further, matters to be disclosed include breaches of the FCA Conduct Rules, the PRA (Prudential Regulation Authority) Conduct Rules and the Conduct Standards and Statements of Principle and Code of Practice for Approved Persons where such breaches resulted in disciplinary action (which is limited to formal written warnings, suspensions as a disciplinary sanction and dismissal).

Ministry of Defence

- 11.16 We met with Wing Commander Nigel Ayers.
- 11.17 There are approximately 150,000 individuals working in the military services.
- 11.18 The MoD do not apply a 'fit and proper person' test but they hold a great deal of information about individuals on a central database, which contains an annual report about each individual (if individuals spend 20 years working in the services, then that means that the MOD could hold 3,000,000 annual reports in total). The annual reports are a detailed assessment of the individual's performance and their potential. At more senior levels, individuals have 360 degree reviews. Further, each individual has a career manager who actively manages their career and their career is managed centrally.

- 11.19 The combination of the amount of people working in the services and the system of annual reporting means that the services possess huge amounts of information about those individuals working within them.
- 11.20 When making decisions about individual promotions, the relevant promotions Board make evidence-based decisions using the information held on the central database.
- 11.21 For senior appointments, the military has a Senior Appointments Committee (the SAC). The SAC considers the individual's CV (which is in a required format) and the last 5 annual reports.
- 11.22 In the military, individuals are taught about leadership from an early stage. The Defence Academy provides training on leadership, strategy and business skills.

General Medical Council

- 11.23 We met with Paul Buckley (Director of Strategy and Policy), Anna Rowland (Assistant Director of Policy, Business Transformation and Safeguarding) and Vibha Sharma (Regulation Policy Manager).
- 11.24 The GMC regulates and licences 290,000 doctors in the UK. The GMC sets standards for doctors (regularly monitored by a process of checks called 'revalidation'), oversees doctors' education and training, manages the UK medical register and investigates and acts upon concerns about doctors.
- 11.25 The GMC does not apply a 'fit and proper person' test but it can undertake a range of actions in respect of a doctor's registration including making a referral to the Medical Practitioners Tribunal Service (MPTS) which has the power to restrict, suspend or revoke a doctor's registration where:
- (a) The allegations against the doctor suggest such a serious failure to meet the GMC's standards that, if proved, their fitness to practise would be impaired. This includes:
- Sexual assault or indecency
 - Violence
 - Improper sexual or emotional relationships
 - Knowingly practising without a licence
 - Unlawful discrimination
 - Dishonest and gross negligence
 - Recklessness about a risk of serious harm to patients

- Serious departures from Good Medical Practice
- (b) A doctor has received a custodial or non-custodial conviction, caution or determination from another regulatory body
- (c) A doctor refuses to agree undertakings

11.26 Further, the GMC has the ability to revoke a doctors' licence where a GMC fitness to practice panel has adjudicated that a doctor has failed to engage adequately with revalidation. Revalidation was introduced in 2012 and requires doctors to demonstrate regularly that they are up to date and fit to practise in 5 yearly cycles which include an annual appraisal process.

Professional Standards Authority

11.27 We spoke to Harry Cayton (Chief Executive Officer).

11.28 The PSA oversees the statutory bodies that regulate health and social care professionals in the UK. It assesses their performance, conducts audits, scrutinises their decisions and reports to Parliament. It also sets standards for organisations holding voluntary registers for health and social care occupations and accredits those that meet them.

11.29 The PSA has set standards for members of NHS Boards and CCGs governing bodies in England. These include standards of personal behaviour, technical competence and business practice. Further, the PSA has set standards described in its 'Fit and Proper Governance in the Public Interest' paper in 2013, some of the key findings of which include:

- (a) That the concept of Board 'accountability' has become too abstract and that its real meaning – personal responsibility – has been lost;
- (b) That too often the qualities which are set out as pre-requisites of public office are too heavily focused on technical competencies and business skills at the expense of the attitudes and values required for governance in the public interest. "Technical competence to serve on a Board is as nothing without personal commitment to the public interest" (paragraph 11.2);
- (c) That Board members should have access to induction and learning and development opportunities;
- (d) That the time is right for a "renewed focus on the moral purpose of public governance and therefore the personal qualities that are appropriate for public office", as highlighted by the 'Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry' and it is "time to focus on the personal qualities and

attributes that are required to ensure that the practice of governance is informed by resilience, diligence, courage and care” (see paragraph 11.1 of “Fit and Proper? Governance in the public interest” March 2013).

Teaching Regulation Agency

- 11.30 We met with Alan Meyrick (Chief Executive Officer).
- 11.31 The TRA regulates the teaching profession by conducting misconduct hearings and maintaining a database of qualified teachers.
- 11.32 The TRA takes action on receipt of allegations of serious misconduct pursuant to the Teachers’ Disciplinary (England) Regulations 2012 as amended by the Teachers’ Disciplinary (Amendment) (England) Regulations 2014. Serious misconduct is conduct that is fundamentally incompatible with being a teacher or could lead to the teacher being prohibited from teaching. The TRA does not concern itself with cases of less serious misconduct, incompetence or under-performance (which it leaves for the teacher’s employer to deal with).
- 11.33 An allegation of serious misconduct is heard by a three-person panel who decide whether there has been: (1) unacceptable professional misconduct, (2) conduct likely to bring the profession into disrepute, (3) a conviction, at any time, of a relevant criminal offence. If the panel decides that there has been conduct falling into any of those three categories it makes a recommendation to the Secretary of State and a senior TRA official decides whether a prohibition order is appropriate. A prohibition order applies for life and where an individual is prohibited, their details will appear on the prohibited list.
- 11.34 In very serious cases, an interim prohibition order is imposed whilst the case is being investigated. There is a right of appeal against a prohibition order via the Queen’s Bench Division of the High Court pursuant to Part 52 of the Civil Procedure Rules. Under some circumstances and after a minimum period of 2 years, the Secretary of State may allow a teacher to apply for the prohibition order to be removed following a recommendation from another TRA panel. The test applied by that panel is whether the individual has demonstrated “clear and unequivocal insight into misconduct that led to prohibition and the extent to which they can demonstrate a clear commitment to adhere to and exhibit the personal and professional conduct elements of the Teachers Standards”.
- 11.35 The TRA does not have the power to impose lesser sanctions than a permanent prohibition order save for the possibility of review after 2 years.

General Dental Council

- 11.36 We met with Ian Brack (Chief Executive Officer).
- 11.37 The GDC registers 41,000 dentists and dental care professionals in the UK. The GDC does not conduct revalidation and licensing of its registrants. It does run a fitness to practice process, which can result in a dentist being disbarred, but it does not apply a test the same or similar to the FPPT.
- 11.38 The GDC is a largely reactionary regulator and effectively waits for complaints to be made. It can then apply a range of sanctions similar to those applied by the GMC.

Healthcare Professions Council

- 11.39 We spoke with Marc Seale (Chief Executive Officer).
- 11.40 The HCPC regulates the health and care professions and keeps a register of them. It has Practice Committee Panels which decide fitness to practise cases. The criteria against which an individual could be considered unfit do not include a test the same or similar to the FPPT.

Overview

- 11.41 Examination of the workings of various other regulators and organisations was a specific requirement within our terms of reference and in a number of respects has provide useful.
- 11.42 It demonstrated that the retention of a large database is regarded as useful in a number of other areas of employment and regulation. The amount of data collected by the armed forces in relation to its personnel and by Ofsted,, demonstrates that the task we are setting for the Central Database Holder is by no means excessive.
- 11.43 The FCA may well provide a useful comparative model for the concept of a mandatory reference requirement.
- 11.44 The TRA has the power to disbar teachers for serious misconduct, but otherwise leaves the disciplinary process in the hands of school Boards.
- 11.45 The GMC has recognised that regular external appraisal and self-development are critical parts of professional life for doctors and imposes that concept through its revalidation scheme.

A REVIEW OF THE FIT AND PROPER PERSON TEST

11.46 In each of these organisations, even where there is no FPPT comparator, we have found useful models which might be applied to the NHS and we have taken the learning of others on Board in formulating our recommendations.

12. Social Care

- 12.1 Social care is a very different animal to the NHS and we do not intend to ‘read across’ our recommendations about the NHS into social care without full consideration, which we have not had time to do.
- 12.2 Our remit, as explained by the Terms of Reference, is to examine the scope of Regulation 5. The social care sector, is regulated by Regulations 5 and 7, which apply to registered managers of care homes.
- 12.3 We consider therefore that further inquiry into the social care sector is advisable given the vulnerability of that particular group of patients, the fact that there are 1.6 million people working in social care and 76% of the adult social care sector is run by ‘for profit’ organisations (as was explained to us by Sharon Blackburn CBE (Policy and Communications director of the National Care Forum).
- 12.4 However, given the size and complexity of social care, the danger of unintended consequences of any recommendations in this area is too high. We do not intend therefore that any of our recommendations should be read across so as to affect the social care sector and should our recommendations be adopted care will have to be taken to ensure that they do not do so.
- 12.5 The only recommendation that we will make about social care, therefore, is that separate consideration should be given in due course to how the regulations work in this complex area.

13. Recommendations

None of the recommendations made below should remove from the Trust Board the overarching responsibility for good corporate governance and the overall responsibility of the Boards of Trusts to protect those working in the hospitals and to protect their patients.

Recommendation One

All directors (executive, non-executive and interim) should meet specified standards of competence to sit on the board of any health providing organisation. Where necessary, training should be available.

- 13.1.1 In order to assist the effectiveness of Boards and Board directors and to encourage people within the service to consider Board posts, we recommend that NHSI should, in consultation with other bodies such as the NHS Leadership Academy and the Academy of Medical Royal Colleges, define, design and set high level core competencies which must be met by any person holding or aspiring to a directorship post (including Interim directors and NEDs⁶⁴) in a Health Trust. Whether or not a director meets the requirements of Regulation 5 (3)(b) should be assessed against the identified competencies.
- 13.1.2 We recommend that the high-level core competencies should be embodied in a schedule to the Regulations and that further guidance should be issued when appropriate by NHSI to set out in detail the competencies to be met by every Health Trust Board Director and equivalent post;
- 13.1.3 We recommend that the required high-level core competencies relevant to directors should include knowledge and a general understanding of the following, no matter what role is undertaken:
- Board governance;
 - Clinical governance;
 - Financial governance;
 - Patient safety and medical management;
 - Recognising the importance of information on clinical outcomes;

⁶⁴ In all of the recommendations below, the references to directors is intended to apply also to NEDs.

- Responding to serious clinical incidents and learning from errors;
 - The importance of learning from whistleblowing and ‘speaking up’;
 - Empowering staff to make autonomous decisions and to raise concerns;
 - Ethical duties towards patients, relatives and staff;
 - Complying and encouraging compliance with the duty of candour;
 - The protection, security and use of data;
 - Current information systems relevant for health services;
 - The importance of issues of equality and diversity both within the hospital in workforce issues and in relation to appointments to the Board; and
 - The importance of complying on a personal basis with the Nolan principles.
- 13.1.4 We recommend that, as part of Trusts’ ongoing responsibility to assess the competency of each member of the Board or those applying for a directorship post, Trusts ensure any necessary training is undertaken by Board members where gaps in competency have been identified.
- 13.1.5 We recommend that when ensuring compliance with Regulation 5 (3) (b) Trusts must have regard to the core competencies listed in the schedule and to any guidance issued by NHSI.
- 13.1.6 We recommend that the CQC should, during the ‘Well-Led’ inspection, review the evidence, including sampling appraisals in respect of the directors, to ensure that they are currently able to meet the core competencies, have regular appraisals and are up to date with personal development plans.
- 13.1.7 We recommend that this approach be kept under review with consideration to be given in due course as to whether a more formalised gateway, registration and validation system is necessary to ensure all directors have acquired and demonstrate the necessary core competencies.

Recommendation Two

That a central database of directors should be created holding relevant information about qualifications and history

- 13.2.1 We recommend that a body (such as NHSI) (hereafter referred to as the Central Database Holder) creates and retains a database which will hold information about each director (including NEDs) to be accessible to potential employers, the NHSI and CQC and where necessary the Health Directors Standards Council (see below). This could be held in any part of the NHSI

system and stored in a 'NHSI Directors' Database'. Until this can be placed on a statutory footing the consent of each director about whom information is held will be required.

13.2.2 We recommend that the database will hold a list of directors and information about each director such as the following:

- Name;
- Current employer;
- Job description of current employment;
- A full employment history and explanation of gaps⁶⁵;
- History of training and development undertaken;
- Available references from previous employers;
- All relevant appraisals and 360 reviews;
- Any upheld disciplinary findings;
- Any upheld grievance findings;
- Any upheld whistleblowing complaint;
- Any upheld finding pursuant to any Trust policies or procedures concerning employee behaviour;
- Any Employment Tribunal judgment relevant to the director's history;
- Any settlement agreements relating to work in any health-related service;
- Criminal convictions; and
- Whether the director is or has ever been disqualified or disbarred as a director.

13.2.3 We recommend that consideration be given to ensuring that the information required to be held by Trusts for provision to the CQC by reason of Regulation 5(5) and Schedule 3 of the Regulations should mirror the information to be held by the Central Database Holder so as not unnecessarily to add a burden to the Trusts' obligations. The CQC should be given access to the Central Database when appropriate to assist them to carry out their function.

13.2.4 We recommend that all relevant employers⁶⁶ be required within a reasonable time to provide to the Central Database Holder the information listed above in [Recommendation 2.2](#) (13.2.2) in relation to each person identified as a director (or those holding equivalent positions) and Trusts should keep the information provided to the Central Database Holder regularly updated and current.

⁶⁵ To be clear any gaps that are because of any protected characteristic as defined in the Equality Act 2010 would not need to be explained.

⁶⁶ To be defined but to include any independent provider from which the NHS commissions health services

- 13.2.5 We recommend that the CQC should review whether or not Trusts have complied with this duty during their 'Well-Led' reviews.
- 13.2.6 We recommend that all relevant employers be required within a reasonable time to identify all those in 'equivalent'⁶⁷ directorial positions whom it considers fall within the Regulation 5 test to the Central Database Holder and to the CQC.

Recommendation Three

The creation of a mandatory reference requirement for each Director

- 13.3.1 We recommend that full, honest and accurate mandatory employment references should be required from any relevant employer where an employee is moving from a post covered by Regulation 5 to a post covered by Regulation 5. Such references must not be subjected to any limitation by the terms of a compromise or settlement agreement and any such attempted limitation shall be regarded as of no effect. The 'old' employer must provide such a reference and the 'new' employer must require one.
- 13.3.2 Where an applicant for a role covered by Regulation 5 is being promoted from a non-Board director position or is moving from a directorship role in an organisation not covered by Regulation 5, the 'new' employer must make every reasonable attempt to obtain a reference meeting the requirements of the mandatory reference form and to acquire any missing information from the 'old' employer and from the incoming employee.
- 13.3.3 We recommend that the precise nature and requirements of the mandatory reference form is to be devised by NHSI in conjunction with the CQC, NHSE, NHSLA and other relevant organisations, although we have drafted a suggested basic template – see [Appendix 3](#);
- 13.3.4 We recommend that each mandatory reference form written for an outgoing director must be signed off by a Board director or other director covered by Regulation 5;

⁶⁷ 2014 Regulations - Reg 5 (2)(b)

- 13.3.5 We recommend that the employee concerned should have the right to see and note a challenge to the accuracy and fairness of the mandatory reference and provide such explanation as he or she wishes to in writing.
- 13.3.6 We recommend that any relevant employer employing a director must require to be furnished with such a reference as is specified and should retain it on its records as well as supplying a copy to the Central Database Holder. We will recommend that, in order to affect this change, Schedule 3 of the Regulations be amended so as to incorporate reference to a mandatory reference form.
- 13.3.7 We recommend that the CQC should review employment references provided by Trusts including forward references as part of their 'Well-Led' review. This assessment should review whether they have met the mandatory reference criteria both for current employees (as directors) and the references written by the employer for onward transmission to future employers. This requirement will only be effective from the date of the recommended amendment to Schedule 3 of the Regulations set out in [Recommendation 3.6](#) (13.3.6) above.
- 13.3.8 We recommend that a failure to comply with the mandatory reference requirement should be considered by the CQC as part of their 'Well-Led' reviews and should lead to the referral of the director signing-off the reference to the Trust or the HDSC for Serious Misconduct where there is evidence of deliberate concealment of relevant information or dishonesty.
- 13.3.9 We recommend that the CQC provides further guidance on this aspect of the Trust's duties.

Recommendation Four

The FPPT should be extended to all Commissioners and other appropriate Arms-Length Bodies (including NHSI and NHSE)

- 13.4.1 We recommend that the principles of the FPPT be extended to apply to all commissioners although because of the current lack of an appropriate regulator of non-providers, we recommend as a first step that the test is extended by means of voluntary adoption.
- 13.4.2 We recommend that a scoping exercise be undertaken with a view to the test being extended by statute to apply to CCGs and appropriate ALBs⁶⁸ (including

⁶⁸ Appendix 2

the CQC, NHSI and NHSE) but that in the meantime the Senior Appointments Guidance be updated and the principle components of the FPPT be adopted.

Recommendation Five

The power to disbar directors for serious misconduct

- 13.5.1 We recommend the setting up of an organisation which will have the power to suspend and to disbar directors covered by Regulation 5, who are found to have committed Serious Misconduct (as defined in [Recommendation 5.2](#) below (13.5.2)). In order to affect this, legislation is likely to be required. Such an organisation could be housed within NHSI, and could be known as the 'Health Directors' Standards Council' (HDSC).
- 13.5.2 We recommend that Serious Misconduct be defined, but should include the following behaviour:
- Criminal convictions for offences leading to a sentence of imprisonment or incompatible with service in the NHS;
 - Dishonesty;
 - Deliberate bullying;
 - Deliberate discrimination, harassment or victimisation;
 - Sexual harassment;
 - Victimisation or knowingly allowing the victimisation of: whistleblowers; those raising concerns with the Freedom to Speak Up Guardian; or those complying with the duty of candour;
 - Causing, facilitating, colluding in, or requiring any staff member to fail to comply with the duty of candour including by means of a settlement or confidentiality agreement;
 - Causing, facilitating or colluding in the reckless mismanagement of an organisation resulting in the compromise of patient safety;
 - Falsification, concealment or suppression of records, data or other information which is required to be provided to any other person or organisation;
 - Encouraging, facilitating or colluding in the falsification, concealment or suppression of records, data or other information which is required to be provided to any other person or organisation;
 - Encouraging, facilitating, or colluding in the provision of false or misleading records, data or other information which is required to be provided to any other person or organisation;

A REVIEW OF THE FIT AND PROPER PERSON TEST

- Without reasonable excuse failing to provide records, data, information or evidence to legitimate statutory or government directed inquiries, reviews or investigations;
 - Without reasonable excuse failure to provide records, data, information or evidence to the CQC or NHSI when requested to do so.
- 13.5.3 We recommend that consideration be given to ensuring that the FPPT, as set out in Regulation 5, incorporates as Serious Misconduct the same issues as described above by listing these factors as a separate schedule to the Regulations.
- 13.5.4 We recommend that in considering allegations of misconduct the following process is adopted:
- All Serious Misconduct where an employee is still employed by the Trust (the relevant Trust) at which the Serious Misconduct is said to have occurred would first have to be investigated by that Trust. Any Serious Misconduct alleged to have occurred at a previous Trust would be investigated by the HDSC; and
 - If following an investigation by the relevant Trust, Serious Misconduct was found to have occurred, the director concerned would require referral to the HDSC. Such a referral would be mandatory.
 - We recommend that there should be separate routes of referral and or escalation or appeal, to the HDSC from Trusts, other institutions (such as the GMC, CQC, NMC, GDC, HCPC, PSA, NGO) or individuals. References from individuals should have to pass a reasonable prospects test⁶⁹.
- 13.5.5 We recommend that the HDSC should have the power permanently to disbar a director although we recommend that the HDSC's powers should also include shorter periods of disbarment.
- 13.5.6 We recommend that the HDSC has the power to impose an interim (paid) suspension while an investigation takes place, of no longer than six months, where the safety of the public or other public interest requires it.
- 13.5.7 We recommend that a director who is currently disbarred by the HDSC may not be regarded as a fit and proper person under Regulation 5.
- 13.5.8 We recommend that the Department of Health and Social Care takes steps to ensure that employment contracts for Board level directors and their equivalents reflect that a finding of Serious Misconduct by the HDSC is to be regarded as gross misconduct for the purposes of the employment contract and would normally operate so as to prevent an individual from receiving notice period monies and any 'golden goodbye'.

⁶⁹ i.e. is there a reasonable prospect that serious misconduct may be found proved

- 13.5.9 We recommend that the CQC and all appropriate ALBs (as set out at [Appendix 2](#)) amend their appointment rules to prevent them employing someone who has been disbarred by the HDSC for Serious Misconduct.
- 13.5.10 We recommend that all NHS commissioners, commissioning services from the independent sector, should be prohibited from commissioning services from any provider where a disbarred or suspended director sits on the Board of the provider or who holds an equivalent director's post.
- 13.5.11 We recommend that if necessary the HDSC be provided with the same powers as the CQC to require Trusts to supply information relevant to the exercise of its powers.
- 13.5.12 We recommend that there be a statutory time limitation period of five years in relation to historic complaints about Serious Misconduct, unless there are exceptional circumstances and the public interest requires action to be taken.
- 13.5.13 We recommend that all other misconduct (not falling to be categorised as serious) ought to continue be dealt with within the employing Trust as a disciplinary issue.
- 13.5.14 We recommend that the HDSC provide a report annually as to its activities.

Recommendation Six

- 13.6.1 We recommend that, in relation to Regulation 5 (3) (d) of the Regulations, the words "been privy to" are removed.

Recommendation Seven

- 13.7.1 We recommend that further work is done to examine how the test works in the context of the provision of social care and whether any amendments are needed to make the test effective.

Recommended amendments

Schedule of potential consequent amendments to Regulation 5 and the corresponding schedules

- 13.8 Consideration should be given to the following amendments to the FPP Regulation:
- i. That in order to give effect to [Recommendation 1](#), a new schedule to the Regulations is created listing required competencies for Board directors and their equivalents, and that a new subparagraph is inserted into Regulation 5 of the Regulations to require consideration of the schedule when assessing whether an individual is compliant with 5 (3) (b) of the Regulations.
 - ii. That in order to give effect to [Recommendation 3](#), that Schedule 3 of the Regulations be amended so as to incorporate reference to the mandatory reference form.
 - iii. That in order to ensure that the test of Serious Misconduct as defined for the purposes of the HDSC is consistent with the FPPR, Regulation 5 (3) (d) of the Regulations be amended so as to require consideration of the same issues as described in [Recommendation 5.2](#) (13.5.2) above.
 - iv. That in order to give effect to [Recommendation 5](#), that Part 1 of Schedule 4 of the Regulations be amended to include anyone disbarred or suspended by the HDSC.

Appendix 1

[Morecambe Bay Investigation](#) report;

We recommend that interested parties read Chapter 4 of the [Morecambe Bay Investigation](#) report.

Appendix 2

Table of appropriate ALBs

Organisation	Role	Staff head count ⁷⁰
Care Quality Commission (CQC)	Independent quality regulator of health and adult social care providers in England	3227
Health Education England (HEE)	Deliver high quality education, training and workforce development in health sector	2655
NHS England	NHS England and NHS Improvement collectively lead the NHS in England, ensuring patients receive high quality care in local health systems that are financially sustainable	6158
NHS Improvement (brings together Monitor and NHS Trust Development Authority)		1369
Public Health England (PHE)	Protect and improve the nation's health and wellbeing, and address health inequalities	5459

⁷⁰ Based on figures provided by the Department of Health and Social Care, correct as of January 2019.

Appendix 3

Mandatory Reference Form

The mandatory reference forms the subject of Recommendation Three. Recommendation Three recommends that “the precise nature and requirements of the mandatory reference form is to be devised by NHSI in conjunction with the CQC, NHSE, NHSLA and other relevant organisations.”

In anticipation of that task, we recommend that consideration is given to including the following elements in the mandatory reference form:

1. Name
2. Job Title and Job Role including essential job functions
3. Employment start date and termination date in each role
4. Salary
5. Learning and development undertaken during employment
6. Attached last three years' 360 degree assessments if available (and explanation of non- availability)
7. Have we the employer had concerns about the individual as not being a fit and proper person to act as a director (whether executive or non-executive)
8. if yes, what was the basis for those concerns and how were they resolved?
9. Any relevant (to the FPPT) information regarding any outstanding or upheld complaint(s) including grievances and whistleblowing complaints or complaints under any of the Trust's policies and procedures (for example under the Trust's equal opportunities policies)
10. Any outstanding or upheld disciplinary action under the Trust's disciplinary procedures including the issue of a formal written warning, disciplinary suspension or dismissal
11. Any outstanding or upheld proceedings under the Health Directors' Standards Council
12. Any other information about the individual's fitness and propriety relevant to the FPPT
13. Whether there was anything that would cause the author of the reference to believe that the individual had engaged in Serious Misconduct as defined in Recommendation Five

A REVIEW OF THE FIT AND PROPER PERSON TEST

14. Whether there was anything which would cause the author of the reference not to re-employ the individual in a similar position

15. Name and position of the author of the reference (such individual to be a Board Director or other director covered by Regulation 5)

16. An acknowledgement that the content of the mandatory reference will form part of the material to be assessed by the CQC in its 'well-led' reviews and will lead to the referral of the director signing off the reference to the Trust or the HDSC for Serious Misconduct (as defined in Recommendation Five) where there is evidence of deliberate concealment of relevant information or dishonesty.

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