Contribution to the Kark Review of the Fit and Proper Persons Requirement

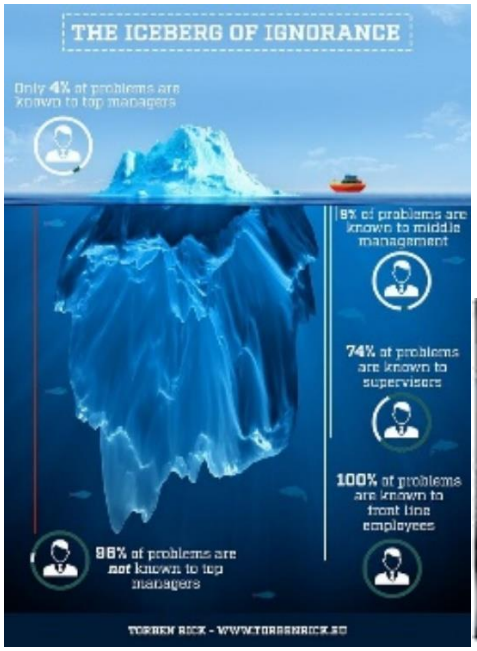
This written contribution is based on my oral submission to the evidence session for National Guardian Advisory Working Group members, 14 August 2018, 12:30–2:00pm.

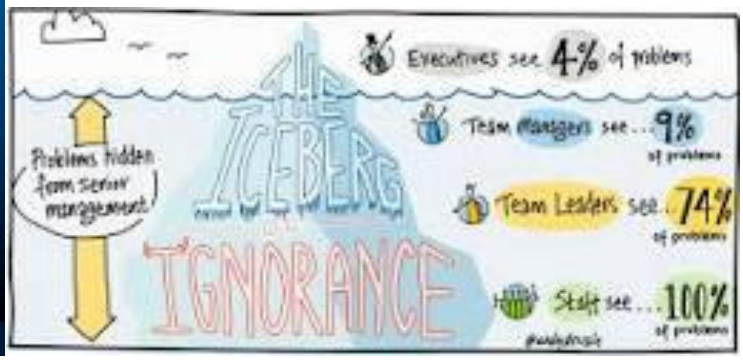
CONTENTS

Introduction

Regulation 5 of the 2014 HSCA Regulated Activities Regulations[1] is aimed at ensuring that people who have director level responsibility for the quality and safety of care, and for meeting the fundamental standards, are fit and proper to do so. The terms of reference for this review[2] include consideration of the scope of Regulation 5. Whilst Regulation 5 explicitly refers to directors and individuals performing similar or equivalent functions, I welcome references in the related DHSC policy paper[3] to *'senior managers'* and ensuring that *'senior staff who are responsible for quality and safety of care'* are fit and proper to be in such roles. I think that the operation of the *Fit and Proper Persons Requirement* (FPPR), if it continues, should be extended beyond directors, to ensure that other senior staff, not necessarily working at director level, are explicitly required to be fit and proper people to undertake managerial roles in the provision of healthcare services.

The *'Iceberg of Ignorance'*





A recent publication[4] attributes the term *'Iceberg of Ignorance'* to Yoshida. It refers to senior level management being so far removed from day-to-day business operations that they fail to understand the systems and processes that affect both employees and customers[5]. Yoshida concluded that only 4% of an organisation's front-line problems are known at executive level, 9% are known by middle management, 74% by team leaders and 100% by staff [4,6].

While the numbers may be debated, the iceberg analogy illustrates the problem of people at board level being at a distance from the coal face, where most of the real issues affecting quality and safety

of care play out. Management hierarchies can result in directors being either unaware of such issues, or being given distorted messages filtered by intervening layers of management. Such layers may have vested interests in giving partial, misleading messages to those above them, and may see virtue in telling those above them what they think they wish to hear.

This can create serious problems in respect of regulatory compliance, service delivery and quality of patient services. It can also lead to unfair disciplinary procedures enacted by middle managers against NHS staff who have raised genuine concerns in the public interest. Raising such concerns can have devastating consequences on the careers, health and well-being of those who raise them, as found by the *Freedom To Speak Up* Review[7].

Declaration of interest

Here I should declare an interest, as I contributed in 2014 to the *Freedom to Speak Up* Review - not knowing at the time that I would be unfairly dismissed by an NHS Foundation Trust the following year - and have in effect lost my career. I have had no income for 3 years, apart from a £9,000 employment tribunal award said to be compensation[8]. There is increasing recognition from many quarters that the ERA/PIDA legislation[9,10] under which this award was made simply does not protect whistleblowers, as was made clear by a number of MPs in a recent Westminster debate (18 July 2018)[11,12]. The *Freedom To Speak Up Review*[7] describes this legislation as '*weak*' and *'limited in effectiveness*'. It was noted in the 18.7.18 Westminster debate that only 3% of whistleblower employment tribunal claims are successful, which gives some idea of the magnitude of the task facing whistleblowers who seek justice. The odds are stacked against them.

The Employment Tribunal which found that I had been unfairly dismissed also confirmed that I had made many protected disclosures, going back over a number of years.

The Care Quality Commission (CQC), during a subsequent inspection of the foundation trust, found failings precisely in areas where I had raised concerns, corroborating what I had been telling numerous managers in the trust for years, to no avail.

I made a self-referral to my professional regulator, the *Health and Care Professions Council* (HCPC), who asked for details from me and the trust, undertook a preliminary investigation, confirmed that they have no concerns about my fitness-to-practice and closed the file.

I also self-referred to my professional body, the *Institute of Physics and Engineering in Medicine* (IPEM), who similarly undertook a preliminary investigation, and confirmed that I had no case to answer. In raising the concerns I was simply doing my job.

Codes of conduct for healthcare professionals

I self-referred to both HCPC and IPEM because of obligation to do so under their respective codes of conduct, having been subjected to disciplinary procedures. Registered healthcare professionals (HCPs) are obliged to raise, and if necessary escalate, concerns under relevant codes of conduct. HCPs who are found to have contravened such codes of conduct are liable to sanctions, including erasure – they can be struck off by regulators regulating their profession. Recent events show that this is no idle threat[13].

Absence of equivalent independently-enforced sanctions applying to unregulated managers

By contrast to the exacting requirements of professional regulation with which healthcare professionals are obliged to comply, healthcare managers are not regulated *per se*. Those who come from professional backgrounds may be subject to codes of conduct for their own professions, though in practice many former HCPs who move from clinical practice into management do not maintain their professional registration. Non-clinical managers are not subject to regulation. Whilst there is a '*Code of Conduct for NHS Managers'* [14] it is not enforced by an independent regulator. Investigations of alleged breaches are at the discretion of local employers - with guidance that appears to be only advisory rather than mandatory that alleged breaches by Chief Executives and Directors *should* (not must) be investigated by outside bodies.

These arrangements seem too cosy in practice, allowing local employers to turn a blind eye to managerial misconduct – and in effect mark their own homework. I think they are a weakness of the current FPPR.

Mid Staffs Public Inquiry Report recommendations about managerial behaviour and accountability

The Report of the Public Inquiry into the appalling care at the Mid Staffordshire Hospital, the Francis Report (5 February 2013), recommended that *'A common code of ethics, standards and conduct for senior board-level healthcare leaders and managers should be produced and steps taken to oblige all such staff to comply with the code and their employers to enforce it'* (Recommendation 215)[15].

It went on to say that *'Serious non-compliance with the code, and in particular non-compliance leading to actual or potential harm to patients, should render board-level leaders and managers liable to be found not fit and proper persons to hold such positions by a fair and proportionate procedure, with the effect of disqualifying them from holding such positions in future.' (Recommendation 218)*[16]

It also recommended consideration of an alternative option: '*An alternative option to enforcing compliance with a management code of conduct, with the risk of disqualification, would be to set up an independent professional regulator. The need for this would be greater if it were thought appropriate to extend a regulatory requirement to a wider range of managers and leaders …*' (Recommendation 219)[17]

I am not aware of a common code of ethics, standards and conduct for senior board-level healthcare leaders and managers having been introduced. I am aware that Robert Francis has re-visited the question of regulation of NHS managers[18], concluding that NHS managers should be subject to professional regulation in the same way that doctors are. Related to this, others have commented on the weakness of sanctions applied to managers whose conduct falls below expected standards[19]. It seems bizarre to me that unregulated managers can have powers to effectively end the careers of NHS staff without any apparent accountability on the part of themselves or the Trust - who surely have vicarious responsibility but appear to be able to escape virtually unscathed when their representatives behave unfairly.

Accountability for dishonesty, unfairness and other ethical lapses

I was angered by trust managers saying things to my detriment during my employment tribunal hearing, under oath/affirmation, which were not true. They seem to have got away with it, which doesn't seem right to me. The Judge picked up some of these, but merely described them as "inconsistencies", which seems a remarkably lenient term for what I would have thought was perjury. Other whistleblowers describe similar experiences in employment tribunals.

I think that trust representatives who say things which are not true in settings where there is an expectation of truthfulness should be held to account. The FPPR Review may wish to consider the extent to which trust boards have responsibility for the actions of subordinate managers representing their trust. It is commonly-held that whilst individuals may be able to delegate actions to subordinates, they are not able to delegate responsibility for the actions of those subordinates. Is

there individual, or collective, responsibility at board level for unfairness, dishonesty and other ethical lapses by trust representatives? Is anybody accountable?

Unfair NHS disciplinary processes

In my opinion cases such as mine should not have to go to a tribunal. The trust had plenty of opportunities to halt the unfair disciplinary process they instigated, and many further opportunities to reach a fair outcome before the tribunal hearings. They have had further opportunities to apologise for the unfairness of the disciplinary action they took against me, and respond to my attempts to seek reconciliation. They passed up all these opportunities.

They must have spent large sums of public money trying to discredit me, both directly in legal fees and indirectly in management and HR staff time involved in the unfair disciplinary action against me. This money would have been much better spent on improving patient services. Instead they embarked on an unfair disciplinary process which has cost me my career - not to mention the substantial cost of litigation which I had to embark on to demonstrate the unfairness of the disciplinary action taken against me. It should not be forgotten that in raising concerns, subsequently corroborated by CQC, I was simply doing my job - my 'reward' was to be treated as a troublemaker.

Others in related circumstances have suffered worse fates than me as a result of unfair disciplinary action taken against them, as evidenced for example, by the recent *Verita* report into the death of Amin Abdullah[20,21].

I am certainly not opposed to good managers and good management. I am a chartered manager in my own right[22], and a Fellow of the *Chartered Management Institute*. I have earned these qualifications and recognition of my managerial abilities based on contributions I have made to the NHS over many years. I want the NHS to be properly managed, by fit and proper persons, and am unhappy when I see the system appearing to turn a blind eye to unfair practices carried out by people appointed to management posts.

Power and responsibility – should NHS managers by regulated?

I do not think that the middle managers and senior managers below board level should be excluded from the scope of FPPR. Particularly if they have powers of dismissal, they should accept

commensurate responsibility for discharging such powers, in accordance with commonly-accepted values, such as honesty, fairness and integrity.

There are many cases in which the behaviour of individual managers can be described as, at best, "misguided", and yet they appear to be able to act with impunity, destroying the careers and lives of NHS staff in the process. I would have thought that their behaviour and actions should be regulated, and suggest that this review provides a timely opportunity to recommend regulation of NHS managers, with effective sanctions to curb managerial misconduct and incompetence.

Misconduct

In my opinion all of the items listed in item 5 of the Terms of Reference for this Review (Appendix 2) should be specified as amounting to 'misconduct'. There are references to several of these, including bullying, concealment/disguise and falsification of records, in Appendix 1.

I would like to suggest the following further items which could be added to this list:

- Acting beyond levels of competence
- Failure to take salient advice from subject matter experts, particularly in regard to patient safety
- Ignoring binding guidance from DHSC/NHS/Regulators, arms-length bodies or similar
- Wilful/reckless disregard of warnings and recommendations from relevant authorities
- Failure to support reasonable expectations of staff in respect of local implementation of national career pathways
- Failure to remediate in a straightforward and fair manner upheld grievances
- Obstruction to requests for a grievance hearing
- Destroying or denying access to physical or intellectual property created by members of staff to which they have a legitimate interest / reasonable expectation of access*

*I think this goes beyond the reference to "inappropriate witholding of records" in the current list.

Perhaps the list could also include wilful failure to abide by the Nolan principles of public life (selflessness, integrity, objectivity, accountability, openness, honesty, and leadership)[23] and other signposts to good conduct such as the NHS Constitution[24] and the (hopefully-strengthened) 'Code of conduct for NHS managers' [14]. I think the Code of conduct for NHS managers[14] should be revised to include a strong emphasis on expectations of observance of ethical standards, in line with a recent

publication from the Committee for Standards in Public Life: '*The Continuing Importance of Ethical Standards for Public Service Providers'* [25].

This publication[25] emphasizes the need for transparency, accountability, moral courage, high ethical standards and ethical standards training. It points out that some providers have focused on reputation management rather than development of an ethics-led service delivery culture. It identifies that *"service providers put an inappropriate amount of emphasis on managing reputation, without acknowledging that it is a symptom of wrongdoing pervading an organisation's approach, rather than a risk itself"*, and includes a reminder that, "*Within the Seven Principles of Public Life, the Selflessness principle requires that holders of public office should take decisions solely in terms of the public interest*".

Incompetence

I agree with the emphasis in the terms of reference requirement for individuals to be of good character, as required in paragraph (3)(a) of Regulation 5 (Appendix 4). Paragraph (3)(b) of Regulation 5 refers to requirements for an individual to have the necessary qualifications, competence, skills and experience for the role for which they are employed. I hope that the review also addresses the question of managerial competence. Perhaps there could be a list of examples of managerial incompetence, equivalent to the list (in item 5 of the terms of reference) for misconduct. For example:

- Creation of unclear of lines of reporting
- Creation of confusion of responsibilities
- Failure to discharge duty of care to staff
- Ignoring specific recommendations made by Occupational Health
- Subjecting staff to unmanageable workloads

… and other basic management failings. Perhaps some of these constitute misconduct rather than incompetence.

NHS management and leadership

Common themes of contemporary management and leadership literature are that traditional "command and control" styles of management and "heroic" concepts of leadership are outmoded. However my experience is that, for all the rhetoric, NHS managers can be extremely dogmatic, directive, and intolerant of independent thinking. There may be an increased tendency for such behaviours with relatively inexperienced middle managers, taking their lead perhaps from messages

intentionally or unintentionally given by senior managers (recognising that the cultural tone in an organisation is, or should be, set by senior leaders).

The landmark Griffiths report 1983[26] which ushered in general management into the NHS emphasized the need for clinical leadership in the NHS[27], but this recommendation is less well known than other recommendations Griffiths made[28]. Challenge of questionable decisions and assumptions made is an important element of leadership, and is welcomed by organisations and individuals mature enough to recognize the legitimacy of appropriate challenge. However, my experience - again in my areas of expertise - is that attempts to engage in clinical leadership can be extremely unwelcome if it is seen as challenging pervading views (particularly if this involves top-down managerial groupthink and/or a self-congratulatory / "good news only" culture).

Speaking truth unto power

An article of this title appears on the Foreign and Colonial Office website[29]. Its opening paragraph reads:

> *The UK Civil Service doesn't have an official motto – but if it did, it would almost certainly be: "speak truth unto power". It's a maxim that's in the blood of good civil servants, even if they know that it won't make their lives any easier. The best politicians learn to cherish civil service advice which points out the flaws in their arguments. The worst surround themselves with sycophants who create a micro-climate which wraps a warm embrace around their worst tendencies.*

Sadly many NHS whistleblowers have discovered that it can be very dangerous to their careers to "speak truth unto power" in the NHS. They may have assumed at the outset that concerns which they raise in the public interest will be well-received by hospital managers, only to discover to their cost realities of the reprisals/retaliation described by Francis in the *Freedom To Speak Up* Review[7]. I hope that the FPPR Review acknowledges that the FPPR has not had any discernible impact in supporting speaking up in the NHS, and that tougher measures are now needed to deter reprisals against those who speak up in the public interest.

Indeed I hope the review goes further, and positively encourages speaking truth unto power, in the interests of the NHS in particular, and a healthier society in general. This would be in line with views expressed by Lock (2017) [30].

Conclusions

I would like to see extension of the scope of the FPPR (if it is continued) to include NHS senior managers below director level. (The term 'senior managers' is open to interpretation – I suspect that some NHS trusts might consider all managers at, say, band 8a or above, to be senior managers.)

Management hierarchy can be a significant contributor to directors and other senior managers being ill-informed about, or completely unaware of, serious matters of concern. There is, in my experience, a real problem with middle managers and others suppressing concerns raised by NHS staff in the public interest. This may be linked to a "good news only" culture which appears endemic within parts of the NHS. Suppression of whistleblower concerns contributes to the "iceberg of ignorance" at board level. The legislation which supposedly protects whistleblowers is weak and, in the eyes of many, ineffective; numerous cases show that NHS staff cannot be sure they will be safe if they raise concerns in the public interest.

Unlike most healthcare professionals, NHS managers are not regulated. The existing '*Code of Conduct for NHS Managers'* lacks teeth. Whilst many NHS managers are decent, hard-working, principled people who abide by values and principles espoused by the NHS Constitution, there is clear evidence that there are some who do not. In my opinion, bullying/dishonest managers are not fit and proper persons to hold such roles. Their behaviour reflects badly on all NHS managers. They should be held to account for bullying dishonest behaviour. Such accountability should be supported by honest fair NHS managers – and by everyone. Dishonesty in legal proceedings, such as employment tribunals, is particularly reprehensible, and should surely have more significant consequences than at present for those who say things which they know to be untrue.

At present, senior managers seem to be insulated from responsibility for misconduct/incompetence of misbehaving middle managers. Whilst this begs the question, perhaps, as to how much such misbehaviour is at the instigation of those above them, it raises the question of to what extent boards, and individual board members, accept and discharge employer vicarious liability for bullying and other misconduct/incompetence by its managers and other employees.

One of the irritating features of NHS managerial behaviour in the eyes of many present and former NHS staff is the failure of individual managers to accept personal responsibility when things go wrong - it is very rare to see any of them prepared to stand up and be counted. It is this lack of

accountability and humility which is at the heart of the distress of many patient representatives and whistleblowers subjected to reprisals/retaliation after raising concerns.

I would like an effective common code of ethics, standards and conduct to be introduced for senior board-level healthcare leaders and managers. I think it should be applicable to all NHS managers, certainly those employed at band 8a and above. For this to be effective, I think it probably should be part of a system of regulation of managers. After all, if healthcare professionals are subject to regulation by an external body, why should managers who have substantial power over them and their careers not be subject to similar oversight of their fitness to practice?

I would like to see the Department of Health and Social Care take a policy stand against the present situation which requires unfairly dismissed NHS staff who have raised concerns in the public interest – in the context of seeking improvements in patient care – to go to an employment tribunal to seek justice. In so doing they face a massive inequality of arms, in which trust managers seem to be able to commit unlimited sums of taxpayers' money to what becomes a jousting match between barristers before a judge/panel on arcane details of weak, ineffective legislation and obscure legal precedent, of sometimes dubious relevance to the concerns raised. There are serious questions as to whose interests are being served (and whose are not being served) by the present system.

I suggest that this (the above paragraph) falls within the remit of the present Review of the FPPR, by linking the behaviour of NHS managers who funnel whistleblowers into an employment tribunal process inherently weighted against them with the Review's terms of reference, which include: the operation and scope of the fit and proper test; bullying and/or harassment; and conduct which discourages appropriate whistleblowing.

I think that whistleblowing cases involving alleged hostility to NHS staff who have raised concerns in the public interest should be handled within the NHS, with the actions of staff being judged by their peers from other NHS organisations who understand the context of their actions. My experience leaves me in no doubt that employment tribunals are not the right forum for this. Whilst some hoped that the National Guardian Office might fulfil this role, it has wide discretion as to whether or not to get involved in a particular case, and appears reluctant to undertake case reviews. There continues to be a gap in the system of oversight in this area, as identified by the Freedom to Speak Up Review[31]. Effective independent review would, in my view, go a long way towards curbing unfair disciplinary actions within the NHS.

I support the inclusion of all the items shown as bullet points in item 5 of the terms of reference as amounting to 'misconduct', and have suggested further items for this list. Furthermore I have suggested that a similar equivalent list be created as examples of managerial incompetence. I think that the Review has an opportunity to underline the importance of the Nolan principles of public life, ethical behaviour, and the NHS Constitution principles and values.

I would like to see improved understanding within the NHS of leadership, and that challenge where appropriate is a fundamental, legitimate component of leadership. Clinical leadership should be encouraged, in line with the 1983 Griffiths Report. At present many healthcare professionals feel seriously disempowered.

There is substantial evidence of retaliation and reprisals against NHS staff who raise concerns in the public interest. I think that the Kark Review has an opportunity to make a substantial contribution to improving speaking up culture, by recommending changes to the FPPR which would provide meaningful sanctions against individuals who inhibit or discourage whistleblowing. Such individuals should be made genuinely accountable for their actions and omissions. I think there is urgent need for legislative reform in this area.

Hugh Wilkins
September 2018

Appendix 1

Illustration of themes in this contribution to the FPPR review by reference to an outline of my circumstances

I am a clinical scientist, formerly Director of Medical Physics and Radiation Protection Adviser at an NHS Foundation Trust. I have worked in hospitals and universities in the UK and overseas, including more than 30 years in the NHS. Much of this work has been in supporting the safe and effective use of radiation in medicine, where it is used widely, for diagnosis, treatment and research.

I was unfairly dismissed by an NHS Foundation Trust after raising concerns in the public interest over a number of years. These concerns were in my professional area of expertise, and raised in the course of discharging my role as head of department and the trust's radiation safety lead. I was trying to improve standards within the trust, but was regarded as a troublemaker by newly-appointed managers in a new senior management structure in the trust for speaking up about the problems I identified. I was subsequently vindicated by an external review and critical CQC report which corroborated the concerns I had raised.

My job description, which didn't change during the 11 years (2004-15) I was employed by the FT which unfairly dismissed me, emphasizes my strategic and operational leadership and managerial roles and responsibilities in respect of medical physics services to the trust. It shows one layer of management between me and the trust board. By the time I left, corporate management layers had proliferated to such an extent that there were seven layers of management between me and the board. A new senior management structure had been introduced in 2013 which resulted in serious managerial ambiguities and confusion of responsibilities, which I believe are at the heart of the employment dispute which was contrived against me[32].

I was the lead subject matter expert in my professional field and radiation safety lead within the trust[33]. I was aware of serious issues affecting patient care. Amongst other things I was seeking to introduce relatively inexpensive improvements to address these issues, but was foiled by relatively junior managers in newly-created posts who over-ruled me, despite their lack of knowledge, experience and relevant qualifications in this area[34].

One of many things which I think is fundamentally wrong in my case is that managers, in the course of suppressing concerns which I raised, went out of their way to alter reports which I had written, and which were presented to managers above them under my name. They seemed to want to give the impression to those above them that things were fine. One even wrote to me, apparently in all seriousness, that it was my role as the trust's Radiation Protection Adviser, to "provide assurance to the Safety & Risk Committee" regarding compliance with legislative requirements - and, it

subsequently emerged, edited my report to include such assurance - even though evidence from audits showed that radiation doses to patients from common x-ray examinations at the trust were higher than national benchmarks, contrary to IRMER legal requirements[35].

Given that radiation is a carcinogen, and given the history of previous serious radiation incidents at the hospital in question - including one which I understand led to the highest litigation pay-outs in the history of the NHS until it was overtaken by the subsequent Bristol paediatric heart surgery scandal[36] - I find their actions extraordinary. And also the action of those above them who knowingly permitted them to behave in this way.

It is almost as if the directors wanted to distance themselves from problems, to protect themselves perhaps from having to take personal responsibility. The FPPR does not seem able to cope with such problems arising from the management hierarchy and culture currently in place.

There is evidence to suggest that one of the people who altered my reports went on to subsequently alter the wording of minutes of the Safety and Risk Committee in a formal trust response to a Freedom of Information request[37], and I believe took other actions intended to discredit me. I don't think that she and others who behaved in this way are fit and proper persons to hold the positions they do/did, and believe they should be held to account. The FPPR as currently constructed appears incapable of providing such accountability in practice.

This is just an outline of my case. There is much more I could say, for example inadequate staffing levels and a recruitment-retention crisis created as a result of local managers ignoring national binding guidance and multiple warnings from national figures. They also ignored recommendations from their own head of occupational health, and refused to accept an individual stress evaluation form which he requested be completed following diagnoses of work-related stress. Managers seemed oblivious to their duty of care towards me, or perhaps thought they could simply ignore it.

I believe I was subjected to sustained bullying over a long period. Repeated NHS staff surveys show bullying at consistent high levels. The new Secretary of State for Health and Social Care, and the Chair of NHS Improvement have indicated their shock at the extent of bullying in the NHS, and the need to reduce it. Whilst bullying is apparently not illegal, it is no way to behave towards a workforce. I hope that bullying and/or harassment is explicitly taken into account, and considered to be 'misconduct' when applying the FPPR.

Appendix 2

FPPR Review Terms of Reference Item 5 - Misconduct

The terms of reference for this review include 11 items which the review will undertake. Item 5 of these terms of reference is to:

'*Consider whether any of the following should be specified as amounting to 'misconduct' so as to be capable of being taken into account when applying the FPPR:*

- *A failure to cooperate with a properly constituted review or investigation;*
- *The failure to preserve records safely or the falsification or inappropriate witholding of records;*
- *Bullying and/or harassment;*
- *Conduct which might inhibit or discourage appropriate whistleblowing;*
- *A failure to secure relevant approvals for, or notify relevant bodies of, any "settlement agreements" and associated payments;*
- *Any failure without reasonable excuse to observe the duty of candour;*
- *Any conduct designed to conceal or disguise any of the acts above.'*

Appendix 3

Government response to the Mid Staffordshire Public Inquiry Report

A House of Commons Library briefing provides background to the public inquiry led by Robert Francis QC and some information on the government's response. *Following the publication of the report, the Prime Minister made a statement to the House, which highlighted how the different layers of NHS management had failed to address the failings at Mid-Staffs NHS Foundation Trust:*

> *The inquiry finds that the appalling suffering at the Mid Staffordshire hospital was primarily caused by a "serious failure" on the part of the trust board, which failed to listen to patients and staff and failed to tackle what Robert Francis calls "an insidious negative culture involving a tolerance of poor standards and a disengagement from managerial and leadership responsibilities."*[38]

The Government's initial response to the Public Inquiry Report (the Francis Report, February 2013) can be found in '*Patients First and Foremost: the Initial Government Response to the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*' [39]. This set out a five-point plan including "*Ensuring robust accountability*":

> *This section stated that as part of the Law Commission's review of the legislation that applies to the professional regulators, the Government would seek to legislate at the earliest opportunity to consolidate measures into a single Act that would enable "faster and more proactive action on individual professional failings". This section also outlined proposals for a barring scheme for "failed NHS managers"*[17]*.*

In its subsequent detailed response to each of the 290 recommendations, '*Hard Truths, the Journey to Putting Patients First',* the Government fully or partially accepted all but nine of the 290 Francis recommendations[40]. It accepted Recommendations 215[15] and 218[16], and partially accepted Recommendation 219[17]. (These three recommendations are discussed on pages 4 and 5 of this document).

The government's response to Recommendation 215[15; 1] refers to standards produced by the Professional Standards Authority ('*Standards for members of NHS boards and Clinical Commissioning Group governing bodies in England')* and an NHS Leadership Academy Publication ('*The Healthy NHS Board 2013')*. It agrees *that the public have the right to expect that people in leading positions*

[1] *Recommendation 215: A common code of ethics, standards and conduct for senior board-level healthcare leaders and managers should be produced and steps taken to oblige all such staff to comply with the code and their employers to enforce it.*

in NHS organisations are fit and proper persons; and that where it is demonstrated that a person is not fit and proper, they should not be able to occupy such a position. It refers to a consultation on '*Strengthening corporate accountability in health and social care'* (July 2013), which led to FPPR. In the light of experience which has led to the Review of the FPPR I think it is appropriate to reconsider Recommendation 215 of *a common code of ethics, standards and conduct for senior board-level healthcare leaders and managers*. I would support such a code, and think it should be extended to include all senior managers. To avoid ambiguity as to which 'senior managers' such a code would apply to, I would suggest that the recommended common code of ethics, standards and conduct be applied not only to senior board-level healthcare leaders, but also to all NHS managers employed at band 8a or above.

The government's response to Recommendation 218[16; 2] also refers to the '*Standards for members of NHS boards …'* publication, and the '*Strengthening corporate accountability …'* consultation, noting that the FPPR scheme *will be kept under review to ensure that it is effective*. It adds *we will legislate in the future if the barring mechanism is not having its desired impact*. Evidence suggests that the FPPR has not had its desired impact.

In its response to Recommendation 219[17; 3] the government agreed that *a focus on standards and their enforcement through normal employment processes and a fit and proper person test is the right place to start*. It added that *further action may be justified following a review of how this approach works in practice*, having seen *how well the combination of a standards-based approach and the use of a 'fit and proper persons' test by the regulators would work*. There have been high profile examples showing that the FPPR has in practice not worked well.

The government's 2014 response did not directly address the possibility alluded to in Recommendation 219 of extending regulation to include *a wider range of managers and leaders*. I think it is hard to justify the present situation in which most healthcare professionals are regulated but managers are not. In this respect I was interested to see a recent article which indicated that

[2] Recommendation 218: Serious non-compliance with the code, and in particular, non-compliance leading to actual or potential harm to patients, should render board-level leaders and managers liable to be found not to be fit and proper persons to hold such positions by a fair and proportionate procedure, with the effect of disqualifying them from holding such positions in future.

[3] Recommendation 219: An alternative option to enforcing compliance with a management code of conduct, with the risk of disqualification, would be to set up an independent professional regulator. The need for this would be greater if it were thought appropriate to extend a regulatory requirement to a wider range of managers and leaders. The proportionality of such a step could be better assessed after reviewing the experience of a licensing provision for directors.

More than 90 per cent of about 80 senior managers surveyed backed idea of professional regulation[41]. I think the time for professional regulation of NHS managers has come, and is overdue.

A 2010 report of a working group (‘*Assuring the quality of senior NHS managers’* [42]) set out recommendations to raise the standards of senior NHS managers. *The report recognises that while the overwhelming majority of NHS managers meet high professional standards everyday, a very small number sometimes demonstrate performance or conduct that lets down the patients they serve as well as their staff and organisations. The group's recommendations include replacing the ‘Code of Conduct for NHS managers’ with a new statement of professional ethics and consultation on a system of professional accreditation for senior NHS managers*.

‘The Healthy NHS Board: Principles for good governance’ **[43]** highlights the consequences of poor board performance on patient care. Its *recommendation 9 makes clear the need for a regulatory and accreditation scheme for senior NHS managers that mirrors those in place for clinicians and nursing staff. One of the proposals contained in ‘Assuring the quality of NHS senior managers’ is to consult on a new system of accreditation for managers that aims to provide stronger assurance of the quality of senior managers in the NHS.*

Both these documents are mentioned in a Department of Health webpage in the national archives referring to the Robert Francis Inquiry report into Mid-Staffordshire NHS Foundation Trust[44].

Appendix 4

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
2014 No. 2936, PART 3, SECTION 1, Regulation 5 *Fit and proper persons: directors*

5.— (1) This regulation applies where a service provider is a health service body.

(2) Unless the individual satisfies all the requirements set out in paragraph (3), the 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, such a director.

(3) The requirements referred to in paragraph (2) are that—

(a) the individual is of good character,

(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,

(c) the individual is able 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,

(d) 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, and

(e) none of the grounds of unfitness specified in Part 1 of Schedule 4 apply to the individual.

(4) In assessing an individual's character for the purposes of paragraph (3)(a), the matters considered must include those listed in Part 2 of Schedule 4.

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

(a) the information specified in Schedule 3, and

(b) such other information as is required to be kept by the service provider under any enactment which is relevant to that individual.

(6) 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.

Appendix 5

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
2014 No. 2936, SCHEDULE 4 *Good character and unfit person tests*

PART 1: Unfit person test

1. The person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged.

2. The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland.

3. The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986(1).

4. The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it.

5. The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland.

6. The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.

PART 2: Good character

7. Whether the person has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence.

8. Whether the person has been erased, removed or struck-off a register of professionals maintained by a regulator of health care or social work professionals.

Appendix 6

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
2014 No. 2936, SCHEDULE 3 *Information required in respect of persons employed or appointed for the purposes of a regulated activity*

1. Proof of identity including a recent photograph.

2. Where required for the purposes of an exempted question in accordance with section 113A(2)(b) of the Police Act 1997(1), a copy of a criminal record certificate issued under section 113A of that Act together with, after the appointed day and where applicable, the information mentioned in section 30A(3) of the Safeguarding Vulnerable Groups Act 2006 (provision of barring information on request)(2).

3. Where required for the purposes of an exempted question asked for a prescribed purpose under section 113B(2)(b) of the Police Act 1997, a copy of an enhanced criminal record certificate issued under section 113B of that Act together with, where applicable, suitability information relating to children or vulnerable adults.

4. 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.

5. 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.

6. 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.

7. A full employment history, together with a satisfactory written explanation of any gaps in employment.

8. 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.

9. For the purposes of this Schedule—

   (a) "the appointed day" means the day on which section 30A of the Safeguarding Vulnerable Groups Act 2006 comes into force;

   (b) "satisfactory" means satisfactory in the opinion of the Commission;

   (c) "suitability information relating to children or vulnerable adults" means the information specified in sections 113BA and 113BB respectively of the Police Act 1997.

References / Notes

[1] The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, *Regulation 5: Fit and proper persons: directors*. https://www.legislation.gov.uk/uksi/2014/2936/regulation/5/made

[2] Department of Health & Social Care, *Kark Review of the Fit and Proper Persons Requirement: Terms of reference and protocol*, July 2018.

[3] DHSC policy paper: *Kark review: terms of reference.* Published 20 July 2018, https://www.gov.uk/government/publications/kark-review-terms-of-reference

[4] *How real leaders melt the iceberg of ignorance with humility*. Corporate rebels, 26 May 2018. https://corporate-rebels.com/iceberg-of-ignorance/

[5] *Organizations rise or fall on their leadership – iceberg of ignorance*. Torbern Rick, 19 May 2016 https://www.torbenrick.eu/blog/leadership/organizations-rise-or-fall-on-their-leadership/

[6] Yoshida, S. (1989), *The Iceberg of ignorance*, International Quality Symposium, Mexico.

[7] *Freedom to Speak Up Review* (2015). http://freedomtospeakup.org.uk/

[8] I was not seeking financial compensation for unfair dismissal, I was seeking an apology and reinstatement / re-engagement.

[9] Employment Rights Act 1996: https://www.legislation.gov.uk/ukpga/1996/18/contents

[10] Public Interest Disclosure Act 1998: https://www.legislation.gov.uk/ukpga/1998/23/contents

[11] House of Commons, Westminster Debate *NHS Whistleblowers and the Public Interest Disclosure Act 1998* Hansard 18 July 2018 Vol 645 https://hansard.parliament.uk/commons/2018-07-18/debates/960EC9A7-68F3-4E87-9846-10706988378E/NHSWhistleblowers

[12] Parliament TV Wednesday Westminster Hall Debate 18 July 2018 4:30pm –5:30pm. https://www.parliament.uk/mps-lords-and-offices/offices/commons/speakers-office/wadjourns/

[13] Vaughan, J. (2018), The long road to justice for Hadiza Bawa-Garba, Br Med J. 14 August 2018 https://blogs.bmj.com/bmj/2018/08/14/jenny-vaughan-the-long-road-to-justice-for-hadiza-bawa-garba/

[14] *Code of Conduct for NHS Managers*, Department of Health (2002)

[15] Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, February 2013, Recommendation 215, Executive Summary p.108

[16] Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, February 2013, Recommendation 218, Executive Summary p.108

[17] Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, February 2013, Recommendation 219, Executive Summary p.108

[18] *NHS managers should face same regulation as doctors, says Francis*. Rimmer A. BMJ 2017;357:j2101 28 April 2017. https://www.bmj.com/content/357/bmj.j2101 https://doi.org/10.1136/bmj.j2101

[19] *On the regulation of NHS managers: it's time to revise the Code of Conduct for NHS Managers.* Shin, GY and Manuel RJ. 11 May 2017 https://www.bmj.com/content/357/bmj.j2101/rr

[20] Independent investigation into the management of the Trust's disciplinary process resulting in the dismissal of Mr Amin Abdullah: A report for Imperial College Healthcare NHS Trust, August 2018. Accessible from https://www.imperial.nhs.uk/about-us/news/investigation-disciplinary-process-actions-and-learning-for-trust

[21] 'Kangaroo courts' shame the NHS, Narinder Kapur, HSJ Comment, 9 August 2018. https://www.hsj.co.uk/policy-and-regulation/kangaroo-courts-shame-the-nhs/7023119.article

[22] My 'chartered manager' award was based on evidence which I collated of management activities which I successfully undertook at the foundation trust which unfairly dismissed me. These activities were in line with management / leadership roles in my job description. The department which I led provided a range of services highly regarded by other departments in the trust.

[23] The 7 principles of public life (the Nolan principles) 31 May 1995. https://www.gov.uk/government/publications/the-7-principles-of-public-life/the-7-principles-of-public-life--2

[24] *The NHS Constitution for England* (updated 14 October 2015). https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england

[25] *The continuing importance of ethical standards for public service providers*. Committee on Standards in Public Life, May 2018. Accessible from https://www.gov.uk/government/publications/the-continuing-importance-of-ethical-standards-for-public-service-providers

[26] *NHS Management Inquiry*, Griffiths (1983). http://www.nhshistory.net/griffiths.html

[27] *The changing role of managers in the NHS*. King's Fund, https://www.kingsfund.org.uk/publications/future-leadership-and-management-nhs/changing-role-of-NHS-managers

[28] *Thirty years on, the Griffiths report makes interesting reading*. Richard Lewis, 21 July 2014. https://www.hsj.co.uk/future-of-nhs-leadership/thirty-years-on-the-griffiths-report-makes-interesting-reading/5072885.article

[29] 'Speak Truth unto power'. Charles Garrett, British Ambassador to Macedonia, 28 September 2015 https://blogs.fco.gov.uk/ukinmacedonia/2015/09/28/speak-truth-unto-power/

[30] *NHS leaders are failing to "speak* truth unto power" David Lock, BMJ 2017*;* 356:j256 19 January 2017. https://www.bmj.com/content/356/bmj.j256.full

[31] *Freedom to Speak Up Review* Executive Summary, para 75 (p. 19) et seq. (Accessible from http://freedomtospeakup.org.uk/the-report/)

[32] My job description was not updated to reflect the new senior management structure, which created multiple additional layers of management in 2013. People appointed to these new roles were for the most part substantially less experienced and less well-qualified than the heads of department whose roles they were in practice seeking to usurp (though this undermining of heads of department was never to my knowledge openly admitted).

[33] I am a qualified expert in relevant fields with my competence assessed by an independent assessing body to undertake specific roles required by legislation (*The Ionising Radiations Regulations 2017*, *The Environmental Permitting (England and Wales) Regulations 2016*, *The Ionising Radiation (Medical Exposure) Regulations 2017* and predecessor legislation).

[34] Managers claimed, incorrectly as shown by subsequent events, that I had exaggerated the risk of a critical report from the CQC. It is noteworthy that the Medical Director had accepted my risk assessment. These middle managers in effect not only over-ruled me, they also over-ruled the trust's Medical Director.

A non-executive director subsequently said that a manager would never over-rule a clinician. He also said that *"there is no bullying in the trust - we have a policy about that"*. These comments illustrate a substantial gulf between the way that things are seen by trust boards and realities experienced by staff.

[35] The Ionising Radiation (Medical Exposure) Regulations 2017. S.I. 2017 No. 1322. http://www.legislation.gov.uk/uksi/2017/1322/contents/made

[36] There were questions asked in Parliament. There are many parallels between that case and my own, including the dismissal of the head of physics, despite his having raised salient concerns which were ignored by managers at the time. (He was subsequently awarded undisclosed damages.) The Committee of Enquiry in that case made many recommendations which were acted upon at the time, but gradually eroded over time, and substantially over-ridden by the senior management structure introduced in the trust in 2013. It was as if there was a loss of corporate memory, a serious failure to learn from experience.

[37] The Trust's response to my Freedom of Information request was seriously delayed, well beyond the time limitation stipulated in the Freedom of Information Act (20 working days). Its response to a Subject Access Request was also seriously delayed, well beyond the time limitation stipulated under the Data Protection Act 1998 (40 days).

[38] House of Commons Library: *The Francis Report (Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry and the Government's response*. Author: Thomas Powell, SN/SP/6690 2 December 2013 https://researchbriefings.parliament.uk/ResearchBriefing/Summary/SN06690

[39] *Patients First and Foremost: The Initial Government Response to the Report of The Mid Staffordshire NHS Foundation Trust Public Inquiry*. March 2013. Cm 8576, ISBN: 9780101857628 https://www.gov.uk/government/publications/government-initial-response-to-the-mid-staffs-report

[40] *Hard Truths, the Journey to Putting Patients First: The Government response to the Mid-Staffordshire NHS Foundation Trust Public Inquiry.* January 2014. Vol 1 (Cm8777-I), Vol 2 (Cm8777-II) ISBN: 9780101877725 https://www.gov.uk/government/publications/mid-staffordshire-nhs-ft-public-inquiry-government-response

[41] *Majority of NHS managers back professional regulation – survey*. https://www.hsj.co.uk/policy-and-regulation/majority-of-nhs-managers-back-professional-regulation-survey/7023201.article

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[44] The National Archives. Department of Health Publications Policy and Guidance: *Robert Francis Inquiry report into Mid-Staffordshire NHS Foundation Trust* http://webarchive.nationalarchives.gov.uk/20130104234315/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113018