AvMA's response to the Department of Health and Social Care Consultation

'Leading the NHS: proposals to regulate NHS managers'

Submitted February 2025

Overall approach to the regulatory model

There are a number of different approaches that can be taken to regulate NHS managers. These range from non-statutory mechanisms such as a voluntary accreditation register, to statutory barring functions through to full statutory registration and revalidation mechanisms.
This section of the consultation asks questions about the most effective approach to the overall model of regulation for NHS managers.

Question: Do you agree or disagree that NHS managers should be regulated?

- Agree

Please explain your answer. (Maximum 300 words)

AvMA is the UK patient safety charity that speaks up for patients when things go wrong with their treatment and care. In our work to champion the needs of people who have been impacted by avoidable medical harm we see clear evidence of the need to regulate NHS managers as a means of bringing individual accountability to those leaders whose decisions directly impact patient care and outcomes, but whose role in healthcare settings can make them "faceless" to the patients they serve. Indeed, working within a system of highly regulated professionals, the lack of regulation of NHS managers is somewhat anomalous.

Time and again we hear that the statutory Duty of Candour was poorly-introduced, misunderstand, patchily embedded and applied. High profile examples, such as the ongoing Thirlwell enquiry, have highlighted that managers have failed to act and respond to patient safety concerns or whistleblowing, and this failure is linked to concerns of reputational risk being prioritised over patient safety. Healthcare professionals have a professional Duty of Candour to patients, but unregulated managers are not held to the same standards, and without a standardised competency framework to support them, poor managers can operate with significant responsibility and little accountability. This must change.

AvMA acknowledges the current ongoing work to by NHS England to develop a leadership and management standards framework. In our role as an independent patient safety charity, it is this work that we feel has the potential to really change the culture and improve standards within the NHS. Regulation, by which we mean appropriate level accountability, proper performance management and rigorous appraisal processes on a par with clinical colleagues, is one facet of this work. It is vital that the introduction of this framework is properly supported and resourced.

Question: Do you agree or disagree that there should be a process to ensure that managers who have committed serious misconduct can never hold a management role in the NHS in the future?

- Agree

Please explain your answer. (Maximum 300 words)

AvMA believes that NHS managers should be held to the same standards as their clinical, regulated colleagues. Where misconduct is proven to have taken place, it should be appropriately dealt with. This could include being struck off and barred from future work within the NHS. It is our hope that greater accountability should result in higher standards of care and a greater focus on patient safety, reducing the need for after the fact litigation and redress.

Whilst there are obvious financial implications to a scheme of this nature, we believe this would be money well spent if it has the desired effect of raising standards. Moreover, anecdotal evidence highlights that poor managers are often moved around the system. We believe stronger regulation would act as a barrier to moving poor performers on or around, with the persistently poorly performing staff being removed from the NHS entirely.

AvMA is unsure of the validity of claims around a possible 'chilling effect' where regulation prevents talented individuals from pursuing a career in NHS management. This does not seem to be an issue given the very great numbers and breadth of regulated roles across a variety of other professions. From a patient perspective, our primary concern is employing people with the skills and commitment to their jobs, and proportionate regulation in and of itself should not prove a barrier to those who are truly driven to perform the role to the required standard. It is however important to stress that regulation alone will not ensure that the aim of raising standards is achieved and maintained. It must be coupled with a commitment to ensuring there is adequate funding and access to training and support for all managers.

Statutory regulatory schemes for healthcare professionals such as doctors and nurses allow for:

- conditions to be placed on their registration
- their registration to be suspended if their fitness to practise is found to be impaired

Question: If there was a disbarring process, do you agree or disagree that the organisation responsible should also have these sanctions available to use against managers who do not meet the required standards?

- Agree

Please explain your answer. (Maximum 300 words)

Regulation of NHS managers should be aligned with that of healthcare professionals and as such, the same sanctions should be available for use against managers who do not meet the required standards.

Reports of an 'Us and Them' culture between managers and clinicians have long existed within the NHS. Bringing NHS managers into regulation should help serve to ameliorate this, and as such sanctions must be consistent.

A professional register

A professional register is a list held by a regulatory body of individuals who are fit to practise in a given profession. A professional register can be mandatory or voluntary. With voluntary accreditation, managers would have the option of joining the register, but with statutory regulation, managers would be required to join the register to be able to practise as a manager in the NHS.

Question: Do you agree or disagree that there should be a professional register of NHS managers (either statutory or voluntary)?

- Agree

Please explain your answer. (Maximum 300 words)

Speaking on behalf of the patients and families we support, we believe a clear and rigorous leadership and management standards framework, suitably funded and resourced to facilitate proper performance management and aligned with the standards expected of clinicians, is how standards within the NHS management body can be most improved. It will be this commitment towards a wider cultural and professional shift that will help to better embed patient safety considerations, including the Duty of Candour, into the heart of decision making.

A form of register is, in our view, the best regulatory tool to sit alongside and support the introduction of such a framework. We hope it would promote and foster quality within its membership body. We are unconvinced that a disbarring service would manage the issues extant within NHS leadership, especially poor performers being quietly shunted around the system and ineffectual day-to-day leadership. Nor would a disbarring service, by itself, contribute towards the greater culture shift towards safety and learning excellence that we campaign for.

Question: If you agreed, do you agree or disagree that joining a register of NHS managers should be a mandatory requirement?

This could be either a statutory requirement or made mandatory through NHS organisations choosing only to appoint individuals to management positions who are members of a voluntary register.

- Strongly agree

Please explain your answer. (Maximum 300 words)

It would be a toothless exercise to go to the trouble of creating a register of NHS managers if participation is not mandatory.

Whether that mandatory requirement is enacted through statutory regulation or through NHS organisations choosing only to employ members of a voluntary scheme is a decision that would need to be taken by those with expertise in implementing regulation of this nature. Certainly, a voluntary register could be set up more quickly and expanded, however we are not persuaded as to whether adherence to only employing registered managers would be consistently met where providers struggle to recruit or current managers who chose not to join such a register. As such, it seems unlikely this approach would achieve its intention.

A grandparenting scheme of sorts would be required to oversee the current NHS managers cohort, and this would require careful consideration and possibly phasing. Once again, this highlights the need for the management and leadership framework to be implemented as a priority, with scope to layer regulation alongside.

Scope of managers to be included

This considers the seniority and roles of managers that a regulatory system should apply to and whether there are other organisations it should apply to. Our starting position is that the regulatory scheme should, as a minimum apply to:

- all board level directors in NHS organisations in England
- arm's length body board level directors
- integrated care board members

Question: Which, if any, of the following categories of managers within NHS organisations do you think a system of regulation should apply to?

- Chairpersons
- Non-executive directors
- Senior strategic level managers and leaders or very senior managers (includes CEOs and executive directors, some medical and dental directors, for example clinical directors)
- Senior managers and leaders (approximately bands 8d to 9, for example service manager, clinical lead, nurse consultant, deputy director or director - usually band 9 - and head of department)
- Mid-level managers and leaders (approximately bands 8a to 8c, for example operations manager, programme manager, senior clinician and matron, up to head of service, for example head of nursing, head of performance and delivery)

Please explain your answer. (Maximum 300 words)

Individuals in board level and executive functions with seniority and strategic oversight should be considered in scope for regulation. At this level, individuals hold extensive responsibilities but are not necessarily in day-to-day contact with those patients they serve. Regulation should be a means of reminding leaders of their core duty to patients.
AvMA believes that mid-level managers also have a level of management responsibility and authority that requires them to be regulated. For example, they may be responsible for making decisions or escalating serious issues to executives which have serious patient safety implications- such as when ambulances are stacking up or an Accident and Emergency department is overwhelmed. They will also be working at a level where their more junior colleagues will report and raise issues with them around issues such as patient safety, staffing and serious incidents. The level of responsibility this requires is such that accountability and regulation should be extended to this level also.

AvMA believes that non-clinical managers should be treated in equivalence with clinical colleagues, many of whom are regulated from their first days in the most junior positions. However, we recognise the multiplicity of roles within NHS management, and the variation

in scope and function. We believe that mid-level management is a proportionate level at which to introduce the regulatory process, with a view to the possibility that further, more junior levels could be included when work has been done to fully understand the variance of operational roles and responsibilities.

Question: Which, if any, of the following categories of managers in equivalent organisations do you think a system of regulation should apply to?

- Appropriate arm's length body board members (for example, NHS England)
- Board level members in all Care Quality Commission (CQC) registered settings
- Managers in the independent sector delivering NHS contracts

Please explain your answer. (Maximum 300 words)

The primary aim of regulation is to protect the public. Regulation should apply to all appropriate arm's length bodies such as NHS England, as they are a part of the NHS system.

There should not be a discrepancy between the oversight of managers in any healthcare setting delivering NHS care. Any manager delivering and providing NHS services has a duty to deliver safe, patient focused care. This would include CQC registered settings providing NHS services, independent sector and social care settings if they provide NHS commissioned care.

The responsible body

The responsible body refers to the organisation that should be responsible for regulating managers. A responsible body may:

- set standards of conduct and competency against which managers are assessed
- hold a register of NHS managers who are registered to practise
- run a disbarring or fitness to practise scheme for NHS managers

Question: If managers are brought into regulation through the introduction of a statutory barring system, which type of organisation do you think should exercise the core regulatory functions outlined above?

- Not applicable - managers should not be regulated through a barring system

Please explain your answer. (Maximum 300 words)

A barring system is predicated on the idea of identifying and removing those unfit to practice only after poor or negligent behaviour has come to light, essentially mopping up after things go wrong. Regulation should be about professionalising and standardising the level of expertise within the system and as such AvMA instead supports the introduction of a professional register.

Question: If managers are brought into regulation through the introduction of a professional register (either a voluntary accredited register or full statutory regulation), which type of organisation do you think should exercise the core regulatory functions outlined above?

- Don't know

Please explain your answer. (Maximum 300 words)

AvMA seeks to offer a patient perspective on NHS manager regulation. As such we do not hold a position on which body should exercise core regulatory functions, so long as the body in question has the resource and expertise necessary to hold the trust to account and confidence of its members, staff and the public it serves.

However, AvMA's experiences with patients who have lost trust and confidence in the NHS's ability to remain impartial when something has gone wrong is such that we wish to highlight the risk that if core regulatory functions are left to an executive agency of the DHSC that patients who are dissatisfied with decisions may feel that the outcome was inevitable. It must be the case that not only things being done, but that they are seen to be done.

We also note the apparent focus of the consultation on the regulatory bodies for doctors and nurses, ignoring those registered with the Health and Care Professions Council. This body regulates nearly 300,000 health and care professionals, from fifteen different professions. Perhaps lessons from the HCPC model would be more appropriate than single profession bodies (noting that the GMC now regulates physician associates and anaesthesia associates).

Question: If managers are brought into some form of regulation, do you have an organisation in mind that should operate the regulatory system? (Select all that apply)

- Don't know

Please explain your answer - if you said an existing regulator, membership body or arm's length body, please specify which. (Maximum 300 words)

Please see comments above. We defer to those with greater expertise in this area. Please refer to our earlier comments about the HCPC and looking beyond just the medical and nursing professions.

Other considerations: professional standards for managers

Professional standards include as a minimum, the values, behaviours and competencies that managers will be expected to demonstrate. There is currently not a set of recognised professional standards for NHS managers. Further work is being undertaken by NHS England to develop professional standards for managers, which could form the foundations for future regulatory standards for managers.

Question: Do you agree or disagree that there should be education or qualification standards that NHS managers are required to demonstrate and are assessed against?

- Strongly agree

Please explain your answer. (Maximum 300 words)

To achieve the aim of raising standards across the NHS, regulation should be supported by education and training for managers to enable them to meet the required standards. In order to regulate, professional standards (including education and training/qualifications) are necessary to assess managers as part of any regulatory process, and align with expectations of clinical colleagues working in the NHS.

Any regulatory framework for managers should be accompanied by a robust and rigorous professional standards framework designed to capture all levels of managerial seniority, competency and skills/qualifications. This should be aligned to recruitment and appraisal practices for such roles. Such a framework should be designed with patients front and centre, and patients and those who support them, should form part of any stakeholder input into the design of a such a framework. Decisions around these standards should also be taken with input from stakeholders, including the healthcare regulators, as a further opportunity to dismantle notions of an 'us and them' culture between clinicians and managers.

AvMA believes that non-clinical managers should be treated in equivalence with clinical colleagues, many of whom are regulated from their first days in the most junior positions. We recognise the multiplicity of roles within NHS management and believe that mid-level management is a proportionate level at which to introduce the regulatory process, with a view to the possibility that further, more junior levels could be included when work has been done to fully understand the variance of operational roles and responsibilities. However, we believe that the management and leadership standards framework should cover all managers, incorporating the principals of the Duty of Candour at all levels to ensure it is a requirement and treated as a priority by all, irrespective of regulation.

Question: If you agreed, which categories of NHS managers should this apply to?

- Chairpersons
- Non-executive directors
- Senior strategic level managers and leaders or very senior managers (includes CEOs and executive directors, some medical and dental directors, for example clinical directors)
- Senior managers and leaders (approximately bands 8d to 9, for example service manager, clinical lead, nurse consultant, deputy director or director - usually band 9 - and head of department)
- Mid-level managers and leaders (approximately bands 8a to 8c, for example operations manager, programme manager, senior clinician and matron, up to head of service, for example head of nursing, head of performance and delivery)

Please explain your answer. (Maximum 300 words)

In order to achieve the aim of raising standards across the NHS, all managers should be supported by education and training which befits their level and need in order to best to fulfil their duty to patients.

Please see our response to the previous question on scope of regulation. At the very least, individuals working as middle managers or above should considered as in scope for regulation, which should stand alongside suitable educational and qualification standards.

Other considerations: revalidation

Revalidation is a periodic check that someone remains fit and competent to remain on a professional register. Certain types of regulation, such as being part of a statutory professional register, can involve a revalidation process. It can include confirming or providing evidence that an individual has kept their skills up to date and continues to meet the standards.

Question: If a professional register is implemented for NHS managers, do you agree or disagree that managers should be required to periodically revalidate their professional registration?

- Agree

Please explain your answer. (Maximum 300 words)

Healthcare is not a fixed discipline. Systems and processes change. Policy and procedures evolve. This is also true for individuals working in the system - they need to be alert to and accepting of change. It would be foolhardy to introduce regulation for managers that did not require revalidation to make sure that skills are maintained and developed, especially as those in clinical roles are required to periodically revalidate.

Of course, this needs to proportionate and not overly arduous or time-consuming in a way that detracts from patient care and safety.

That's why the introduction of professional standards and the development of the discipline and rigour around NHS management is as important as the act of regulation itself.

The HCPC methodology of requiring evidence of CPD relevant to the registrant's area of practice, could be considered as an alternative model to revalidation.

Question: If you agreed, how frequently should managers be required to revalidate their professional registration?

- Don't know

Please explain your answer. (Maximum 300 words)

AvMA provides a patient perspective. We do not a have fixed opinion of the revalidation standards required for managers, although we would suggest that decisions around this involve input the healthcare regulators to ensure that expectations for clinical / non-clinical managers are consistent.

Question: What skills and competencies do you think managers would need to keep up to date in order to revalidate? (Maximum 300 words)

We defer to those with expertise in regulation and revalidation, however we would expect individuals to evidence the requirements of the management and leadership standards framework. We would highlight the importance of ensuring that the Duty of Candour is considered of primary importance and not treated as a "tick box exercise" and would want revalidation to help facilitate that shift in culture towards learning and improvement by pushing members to highlight outcomes of their professional activities rather than just outputs.

Depending on role specificities, this could mean being able to identify how many Duty of Candour and patient safety issues were raised by staff and patients, referrals to the coroner, or PSIRF reports written coming from their department. Shifting from outputs to outcomes would also mean a focus on knowing how these issues have been resolved, changes that have been made, outcomes of any inquests or whether any Action Plans submitted to the coroner have been implemented, or if any recommendations were made in the PSIRF and if so how these have been implemented. Ensuring the board is updated and aware of issues of this nature. Embedding a Director of Patient Safety in all Boards would hugely support this.

These actions move the focus of revalidation for managers towards improving the culture of learning and improving from patient safety issues whilst identifying ways in which that accountability is tested.

If single registration as either a manager or registered clinician goes forward, then those bodies regulating clinicians should be required to assess leadership and management competencies as part of revalidation or CPD assessment to re-register.

Other considerations: clinical managers and dual registration

Dual registration is where individuals are required to register with more than one professional regulatory body at a time. Many individuals who hold management and leadership positions in the NHS will also be registered clinicians, who are already regulated as part of their clinical profession.

Question: Do you agree or disagree that clinical managers should be required to meet the same management and leadership standards as non-clinical managers?

- Agree

Please explain your answer. (Maximum 300 words)

It should not be the case the clinical and non-clinical mangers are held to different management and leadership standards, given that their responsibilities to the patient population that they serve are the same. Given that non-clinical managers are not currently regulated it would be appropriate for those tasked with developing the standards work with healthcare regulators to ensure that leadership and management standards are consistent.

Question: If you agreed, how should clinical managers be assessed against leadership or management standards?

- They should only be required to hold registration with their existing healthcare professional regulator who will hold them to account to the same leadership competencies as non-clinical managers

Please explain your answer. (Maximum 300 words)

It is AvMA's view that it would be unnecessarily burdensome for clinicals to hold dual registration and may prevent talented clinicians from moving into managerial roles, providing that is that their clinical regulators leadership management standards are as robust as that which is agreed for NHS Managers. The need for alignment between professional and managerial regulation is important here.

If standards of management and leadership are developed and tested for consistency it would be entirely appropriate for healthcare regulators to continue to be solely responsible in holding members accountable for those standards.

We do note that many excellent leaders come up through the ranks of clinical professions into senior management positions. However, we understand that leadership and management skills training can be at best inconsistent for this group. Specific training should at least be encouraged, possible mandated through annual/biannual CPD, beyond the standard Statutory and Mandatory Training regime.

Other considerations: phasing of a regulatory scheme

A phased approach may begin with the implementation of a voluntary register or a barring mechanism, with a view to transitioning to a full system of regulation in the longer term.

Question: Do you agree or disagree that a phased approach should be taken to regulate NHS managers?

- Agree

Please explain your answer. (Maximum 300 words)

It is likely that a phased approach would be required given the scope of regulation that needs to be introduced. A phasing system would also provide the opportunity to gather evidence on the successful introduction of regulation as it happens.

AvMA acknowledges that many NHS managers are already doing a very good job. It would not be a good outcome if regulation was introduced and required in so short a time as to encourage a mass exodus of these good managers.

Duty of candour for NHS leaders

The professional duty of candour forms part of the professional standards for regulated professions, overseen by professional regulators such as the GMC, NMC and HCPC to encourage open behaviour. There is also a statutory (organisational) duty of candour.

Question: If managers are brought into a statutory system of regulation, do you agree or disagree that individuals in NHS leadership positions should have a professional duty of candour as part of the standards they are required to meet?

- Strongly agree

Please explain your answer. (Maximum 300 words)

A professional duty of candour already exists for clinicians. Throughout this consultation response AvMA has consistently reiterated the need for clinical and non-clinical managers to be held to consistent, shared leadership and management standards. As such we feel that NHS managers should also have to meet a professional duty of candour as part of the standards they are required to meet.

Patient safety cannot be a faceless commitment that is discussed in boardrooms but left for clinicians on wards to manage. It is essential that individuals in NHS leadership and management positions are required to undertake the same level of personal accountability. Moreover, they must ensure that these issues are referred up to board level and that the most senior colleagues in organisations are aware. Once again, we highlight the importance of the need for all boards to have a Director of Patient Safety. A professional duty of candour applying equally to managers and leaders is an important step to pushing patient safety into the heart of organisational decision making within the NHS.

This cannot become a “tick box exercise” or seen as a necessary action to offset reputational risk. A professional duty of candour for non-clinical managers needs to be framed as part of a wider culture shift towards genuine patient-centred care, committed to learning from errors and resolving issues in ways that empower patients and staff – achieving the best and most holistic outcome for all parties. That’s why AvMA believes that the introduction of a professional duty of candour must be supported by a standards framework that is built towards driving excellence through measurement of learning and outcomes around safety incidents, rather than an output measure that the duty is currently applied.

Question: If you agreed, which categories of NHS managers should a professional duty of candour apply to?

- Chairpersons
- Non-executive directors
- Senior strategic level managers and leaders or very senior managers (includes CEOs and executive directors, some medical and dental directors, for example clinical directors)
- Senior managers and leaders (approximately bands 8d to 9, for example service manager, clinical lead, nurse consultant, deputy director or director - usually band 9 - and head of department)
- Mid-level managers and leaders (approximately bands 8a to 8c, for example operations manager, programme manager, senior clinician and matron, up to head of service, for example head of nursing, head of performance and delivery)

Please explain your answer. (Maximum 300 words)

The Duty of Candour is an important means for patients to understand what has gone wrong and begin a conversation to understand and put right what has happened. Applied correctly it does foster learning and better outcomes for all involved. It connects NHS managers with their core duties to patients.

We believe a professional duty should align with all those that are being regulated, which should include mid-level managers given their senior level of responsibilities which directly impact upon patient care and safety. This serves as a good starting point, with a view to expanding to more junior managers if required and to achieve parity with most clinicians. We recognise that the most junior managers, like their clinical colleagues, can cause or witness harm. However, extending the Duty of Candour to this group would mean that they should be regulated as the means by which the Duty of Candour is enforceable. It is our view that more work should be undertaken to understand the variation in roles and responsibilities at this level prior to extending regulation to all in this group. We acknowledge the lacuna that exists in our response here and highlight the need for any decision around regulation to also include consideration of those who may sit outside the regulatory framework, hence our belief that the management and leadership professional standards should incorporate the principals of the Duty of Candour at all levels.

Additionally, the Duty of Candour could apply to ALL NHS staff, albeit recognising that those in more junior roles with have more limited responsibilities, working as they are in a hierarchy of responsibility and accountability.

There is an existing organisational statutory duty of candour that already applies to providers.

Question: Do you agree or disagree that NHS leaders should have a duty to ensure that the statutory duty of candour?

- Strongly agree

Please explain your answer. (Maximum 300 words)

There is agreement from voices across the NHS that the statutory Duty of Candour is not consistently applied, in its 2024 review, the DHSC itself acknowledged concerns that the duty is not always met as intended in regulation 20. Indeed, the existence of this question highlights how inconsistently the Duty of Candour has so far been introduced and embedded within the NHS: there is not clarity within NHS as to whom has responsibility for ensuring the duty is met.

Failure to comply with the duty can lead to a breakdown in trust between patients and service users and their health or care providers. From our own experience we know that many patients and their families are unaware that the Duty of Candour even exists, and their experience suggests that it is routinely not followed in the spirit of how it was intended to be applied.

NHS leaders should already have a duty to ensure that the existing statutory (organisational) duty of candour is correctly followed in their organisation and be held accountable for this. Once again, this highlights the clear need for NHS managers to have a leadership and management standards framework by which they have personal accountability to the organisation and the patient population that they serve.

Question: If you agreed, which categories of NHS managers should the statutory duty of candour apply to?

- Chairpersons
- Non-executive directors
- Senior strategic level managers and leaders or very senior managers (includes CEOs and executive directors, some medical and dental directors, for example clinical directors)
- Senior managers and leaders (approximately bands 8d to 9, for example service manager, clinical lead, nurse consultant, deputy director or director - usually band 9 - and head of department)
- Mid-level managers and leaders (approximately bands 8a to 8c, for example operations manager, programme manager, senior clinician and matron, up to head of service, for example head of nursing, head of performance and delivery)

Please explain your answer. (Maximum 300 words)

The Duty of Candour is an important means for patients to understand what has gone wrong and begin a conversation to understand and put right what has happened. Applied correctly it does foster learning and better outcomes for all involved. It connects NHS managers with their core duties to patients.

Consistent with our earlier comments, we believe responsibility for ensuring that the statutory Duty of Candour is met should align with all those that are being regulated, which should include mid-level managers given their senior level of responsibilities which directly impact upon patient care and safety.

It is very important that staff at all levels are aware of the Duty of Candour and we have been clear throughout our response to this consultation that the standards framework must incorporate the principles of the Duty of Candour and the importance of reporting issues up the chain, for all managers regardless of seniority.

NHS leaders' duty to respond to safety incidents

This considers if a duty should be applied to NHS leaders in relation to recording, considering and responding to any concerns about the provision of healthcare that might be brought to their attention.

Question: Do you agree or disagree that individuals in NHS leadership positions should have a statutory duty to record, consider and respond to any concern raised about healthcare being provided, or the way it is being provided?

- Strongly agree

Please explain your answer. (Maximum 300 words)

AvMA has supported and helped over 100,000 people who have suffered from avoidable medical harm; our telephone helpline alone receives upwards of 2,000 calls annually. More can be done at an organisational level to improve patient safety. Raising and acting on concerns is key to driving up standards.

NHS leaders must have direct accountability to record, consider and respond to concerns about healthcare provided in their organisation. Unfortunately, the current system, where NHS leaders do not have accountability, isn't working.

We should not have to wait for another national scandal or review to suggest that NHS leaders need to do more. Regulation comes with significant costs to the NHS, so we need to be assured of adding value through this process. Introducing a backstop by which NHS leaders have a statutory duty to tackle concerns about poor care would be an outcome worthy of the investment. Although a statutory duty on its own will not change the culture within the NHS, nor would it be an improvement for another statutory duty to be inconsistently introduced and embedded. A fully functional leadership and management standards framework, outcome driven, with fulsome performance management and rigorous maintenance of standards, is the real driver for success.

In considering this issue AvMa notes that different individuals have differing thresholds for 'importance'. In order to ensure consistency, all concerns raised should be formally assessed as part of a risk register. This would tease out the level of risk that exists and ensure senior oversight. More junior managers may not have the managerial experience and/or weight to elicit changes which a proper response may require. However, there must be a recognition of the need to report so that these issues come to the attention of leadership and ultimately the Board who must take overall responsibility for complaints.

Question: If you agreed, which categories of NHS managers should this apply to?

- Chairpersons
- Non-executive directors
- Senior strategic level managers and leaders or very senior managers (includes CEOs and executive directors, some medical and dental directors, for example clinical directors)
- Senior managers and leaders (approximately bands 8d to 9, for example service manager, clinical lead, nurse consultant, deputy director or director - usually band 9 - and head of department)
- Mid-level managers and leaders (approximately bands 8a to 8c, for example operations manager, programme manager, senior clinician and matron, up to head of service, for example head of nursing, head of performance and delivery)

Please explain your answer. (Maximum 300 words)

Aligned with our earlier views on professional regulation more generally, we believe individuals with impactful decision-making capability and responsibility, such as middle-level managers and those with increasing levels of seniority and strategic oversight should be considered in scope. It is important to acknowledge that those at the more junior end of this group may be limited by the decisions of those above them and may not be able to alter processes or take action on their own without agreement of their senior colleagues. Guidance or regulation must therefore acknowledge and reference this.

As noted above, is our view that more work should be undertaken to understand the variation in roles and responsibilities of the most junior managers prior to extending regulation to all in this group. However, there should still be an obligation for more junior team members to report safety concerns, act on them where possible and ensure that issues are raised with senior colleagues. If left unregulated, more junior managers should still sit within a professional standards framework which highlights a responsibility to report safety concerns all levels.

Question: Do you agree or disagree that individuals in NHS leadership positions should have a statutory duty to ensure that existing processes in place for recording, considering and responding to concerns about healthcare provision are being correctly followed?

- Strongly agree

Please explain your answer. (Maximum 300 words)

It should be a cornerstone of the work of NHS leadership to ensure the processes in place for recording, considering and responding to concerns about healthcare provision are being correctly followed.

That this isn't consistently the case, even anecdotally, suggests that NHS leadership needs greater oversight.

Once again, the need for a management and leadership standards framework is abundantly clear. This framework, supported by suitable appraisal and performance measurement, should form part of the matrix which ensures NHS leaders are meeting these requirements and enhances the culture shift towards excellence and greater professionalism. At more junior levels this should include an expectation to report concerns as they may be unable to elicit changes themselves. This should be supported by a regulatory framework which ensures that processes are being followed at every level, and formalising appraisal processes are in place to ensure standards are driven up, and providing teeth when standards are not met.

Question: If you agreed, which categories of NHS managers should this apply to?

- Chairpersons
- Non-executive directors
- Senior strategic level managers and leaders or very senior managers (includes CEOs and executive directors, some medical and dental directors, for example clinical directors)
- Senior managers and leaders (approximately bands 8d to 9, for example service manager, clinical lead, nurse consultant, deputy director or director - usually band 9 - and head of department)
- Mid-level managers and leaders (approximately bands 8a to 8c, for example operations manager, programme manager, senior clinician and matron, up to head of service, for example head of nursing, head of performance and delivery)

Please explain your answer.

Please see our answers above. Aligned with our earlier views on professional regulation more generally, we think individuals with impactful decision-making capability and responsibility, such as middle-level managers and those with increasing levels of seniority and strategic oversight should be considered in scope. It is important to acknowledge that those at the more junior end of this group may be limited by the decisions of those above them and may not be able to ensure adherence to processes without agreement of their senior colleagues. Guidance or regulation must therefore acknowledge and reference this.