General Medical Council

Leading the NHS: proposals to regulate NHS managers – Consultation questions

Link to consultation document

Overall approach to the regulatory model

1. **Do you agree or disagree that NHS managers should be regulated?**

No view.

We agree with your proposal that ''The regulatory system must therefore be designed around the specific risks and requirements of NHS managers.' However, we believe that further thought first needs to be given to the nature of these risks and requirements before coming to a view on whether regulation presents a proportionate solution for addressing these.

As noted in your consultation document, the Professional Standards Authority for Health and Social Care's (PSA) paper on Right-touch regulation (revised in 2015) highlights the need to balance risk against regulatory force by 'understanding the problem before jumping to the solution'. However, it is not yet clear that the problem being solved has been fully defined.

Once this has been addressed and a decision taken on whether regulation is required, further consideration can be given to the cohort that should be subject to regulation as well as the nature of that regulatory framework, taking into account the adequacy of existing levels of oversight and scrutiny that exist for NHS managers.

The regulatory approach and the model you adopt will depend on what it is you are trying to achieve. A barring system may be appropriate if the primary purpose of regulation is to punish serious misconduct and prevent individuals from working in leadership roles. Alternatively, if the main aim is to support the development and maintenance of good practice (while also acting on misconduct and poor practice) then a more sophisticated model built around educational and professional standards might be more appropriate.

Alongside any assessment of risk, consideration should also be given to whether the profession is ready to be regulated. This would take into account whether:

- The profession is a clearly definable and differentiated group has a clear role
- there is a defined body of knowledge and standards for that particular group
- there are established training pathways for the education of future professionals

- there is infrastructure in place to support the delivery of the duties and responsibilities associated with a regulated profession.

Given the broad scope of roles that encompass the NHS manager cohort it may be sensible to introduce regulation in a phased way. This could be achieved in one of two ways. First of all, regulation could be targeted at the group where the greatest risk lies.

Alternatively, and historically, new professional groups have established their identity, role and standards first through a voluntary system, before statutory regulation was considered appropriate.

The advantage of having a targeted and incremental approach would be to allow time to develop the appropriate training and education pathways along with the supporting infrastructure needed to regulate a new profession.

The impact of a voluntary regulatory approach could be further enhanced if the NHS were to make the joining of voluntary register a condition of employment. Equally, the register could be established as an accredited register administered by the PSA.

2. **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?**

Whilst we agree in principle, we do not agree on an absolute basis.

On the basis that regulation is considered to be necessary for NHS managers, we agree that the 'regulator' should have the ability to investigate concerns about the behaviour, health or performance of an individual manager. We also agree that sanctions should be available to the regulator if it is determined that patent safety, or public confidence in NHS managers as a professional group, is at risk. For cases of serious misconduct the appropriate sanctions might be suspension or removal of the individual from a regulator's register.

Normally, however, statutory professional regulatory systems do not impose an absolute and permanent ban, and there are provisions that would allow an individual to apply to be reinstated after a period of time, provided they can demonstrate that they meet certain requirements – for example, that they possess the necessary knowledge, skills and experience, and that their fitness to practise is no longer impaired.

As part of our regulatory framework for doctors, PAs and AAs, individual registrants who have been removed from the register due to a fitness to practise concern are permitted to apply for restoration (doctors) or re-entry (PAs and AAs) after 5 years. They would be able to be restored/re-entered onto the register if they can demonstrate that they meet our requirements for registration (which includes demonstrating that they are also now fit to practise).

3. **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**

Not sure.

If a disbarring service were to be created it would preclude the use of lesser sanctions and warnings. If you are proposing to create a disbarring service that is able to use a variety of sanctions, or a professional register that disbars registrants, this would be a significant departure from the regulatory models that we are familiar with. It may be that this question is conflating two different approaches to regulation.

There may also be instances where it is disproportionate to disbar an individual for failing to meet the required standards, depending on the nature of the breach and the level of risk posed to public protection and public confidence. This means that opportunities to enforce the standards and/or address lower level concerns will be missed – which if unchecked, may lead to more serious departures from the standards further on. Equally, an individual manager may have health concerns which affects their ability to practise in accordance with the standards – it such circumstances, it may be fairer, more compassionate and indeed more proportionate to utilise a less punitive sanction, rather than simply resort to disbarring.

The alternatives to creating a disbarring service could make use of less punitive sanctions such as conditions, suspensions and warnings, contrasting with the binary choice of either disbarring an individual or taking no action at all.

The ability to utilise a range of sanctions in this way would therefore enable more proportionate and targeted action to be taken when risks arise – in keeping with the PSA principles of right touch regulation.

A professional register

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

Agree.

If it is decided that regulation is necessary, then information relating to that regulatory framework must be accessible and transparent. We therefore agree that a professional register would provide clarity to the public, employers, and other stakeholders that an individual possesses the necessary knowledge, skills and experience to practise as a manager.

Establishing a professional register will focus attention on the majority of individuals who practise safely and competently as opposed to focusing on the minority who do not through a barring scheme. This is in keeping with modern, supportive models of regulation where the focus is on ensuring that everybody has met the same standard of registration, and therefore has the necessary knowledge, skills, and experience to practise as a senior manager. This would align with the views and recommendations of the Messenger Review, 2022, which were accepted by the government at the time. These recommendations included:

- Targeted interventions on collaborative leadership and organisational values
- Consistent management standards delivered through accredited training

To enter the register, in addition to demonstrating the relevant knowledge, skills and experience for registration, it is also essential that individuals are required to demonstrate that they are fit to practise with no outstanding concerns.

Once registered, it is also important that any regulatory action taken in response to concerns raised is clearly published on the register. Concerns will need to be anchored around a common framework of professional standards, which commands the support of that group, and draws on the perspectives of all who interact with them.

5. **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.

No view.

If it is decided that regulation (as distinct from a barring scheme) is appropriate, then it follows that for regulation to be effective those subject to regulation should be required to be on the relevant register. To achieve this through voluntary regulation (as opposed to a statutory requirement), would require NHS organisations, as a matter of policy and contract, to only appoint individuals who are on the relevant register.

Consideration does need to be given to the issue of dual registration for those already on other professional registers where they may already be subject to requirements/standards relating to leadership and management. There are precedents which allow the possibility of dual

registration (and regulation) without making it a requirement (which is currently the case for oral and maxillo-facial surgeons).

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

6. **Which, if any, of the following categories of managers within NHS organisations do you think a system of regulation should apply to? (Select all that apply)**

No view.

We do not have a view on the level of seniority or type of role that a new regulatory model should apply to. We would suggest that any decision on this take into account the nature of the problem that regulation is seeking to solve, and what level of existing scrutiny is already in place for these individuals. Given the broad scope of roles that encompass the NHS manager cohort, it might be more proportionate to take a phased approach to regulation, beginning with those groups for which there is evidence of higher levels of risk.

However, the restriction of scope to those employed in the NHS only, rather than across NHS and independent sector organisations (where the risks would be assumed to be common) is an issue we suggest needs further consideration. In particular if any form of statutory regulation is to be pursued, restricting its coverage to one type of employer would be a departure from the way that other professional regulatory systems operate in healthcare.

7. **Which, if any, of the following categories of managers in equivalent organisations do you think a system of regulation should apply to? (Select all that apply)**

No view.

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

8. **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?**

We do not have a view. However, we would add that if regulation is being introduced to command public confidence on the one hand, and provide assurance of quality and reliability on the other, then it will be important for the relevant organisation to be independent of Government, and the management of the NHS, to provide credibility.

Additionally, given existing concerns about the complexity, overlap and number of regulatory bodies that already work across the healthcare landscape, any decision to create a new regulatory body should be considered carefully. We would suggest that consideration should first be given to whether an existing body is already well placed to take on this responsibility.

9. **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?**

We do not have a view. But as above, if regulation is being introduced to command public confidence on the one hand, and provide assurance of quality and reliability on the other, then it will be important for the relevant organisation to be independent of Government, and the management of the NHS, to provide credibility.

10. **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)**

We do not have a view. However, as above, consideration should be given to whether an existing body is well placed to assume responsibility for regulating managers.

Other considerations: professional standards for managers

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

Agree (on the basis that a decision is taken to regulate NHS managers).

As we have noted in our responses to the questions above, good practice in modern professional regulation focuses on supporting the majority in practising to high standards rather than just the sanctioning (through disbarring) of the small minority who depart from those standards.

Regulation can enable this by maintaining a list of those individuals (the register) who are, and remain, eligible to practise, with eligibility conferred on those who possess the required knowledge, skills and experience to be registered.

But this in turn must be supported by an established educational and professional infrastructure to help individuals acquire the knowledge, skills and experience expected of them.

However, if it is decided that managers should not be regulated, it may still be desirable for the NHS to strengthen management and leadership standards, and to provide opportunities for those occupying leadership and management roles to foster their continuing professional development. Improving managers' access to further training and education in this way will also help to professionalise these roles.

If you agreed, which categories of NHS managers should this apply to? (Select all that apply)

No view.

Other considerations: revalidation

13. **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.

Should a professional register be introduced, then we agree that NHS managers, like other regulated professionals should be able to demonstrate that they remain fit to practise to maintain their registration.

While revalidation is currently an important process for doctors to demonstrate their continued competence, and for maintaining patient and public confidence in the professions who are caring for them, it is not the only way in which this can be achieved. Different professions use different models for demonstrating that they remain up to date with their knowledge and skills, and remain fit to practise.

Therefore, further thought would need to be given as to what would be the most appropriate and proportionate model for managers to demonstrate their continued competence.

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

While doctors are required to demonstrate to the GMC once every 5 years that they are up to date and fit to practise, they are required to engage with the processes underpinning revalidation throughout those five years.

The frequency for managers would be dependent on the mechanism used to revalidate, the complexity and level of risk concerning the individual role, the rate at which the knowledge required to undertake the role is likely to change, and the rate at which the skills needed are likely to decline.

Other considerations: clinical managers and dual registration

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

Agree.

The characteristics, values and behaviours that enshrine effective leadership and management are likely to apply to all forms of NHS management, and therefore we agree that clinical and non-clinical managers should be subject to a common set of standards.

Clinical managers who are registered with the GMC are already subject to our guidance relating to leadership and management, and later this year, we will be reviewing both *Leadership and management (2012)* and *Raising and acting on concerns about patient safety (2012)*. Both sets of guidance already address some of the issues identified in the consultation document and our

updates will draw on our core guidance *Good medical practice* (2024), which strengthened the duties on senior leaders to:

- demonstrate leadership behaviours
- create a supportive culture and
- to take action when concerns are raised with them

Clinical managers, provided they are registered with us are already required to meet the standards set out within our guidance – in both their personal and professional lives. Therefore, any proposal to introduce a new set of standards that applies to all managers will need to align with those that already exist for other registered healthcare professionals that occupy senior positions of management and leadership.

For this reason, and to promote alignment with our existing guidance, we are providing input to the work led by NHS England to create a new framework for all NHS leaders and managers in England, comprising a code of conduct, standards and competencies for different levels of management and leadership, and core curricula to inform teaching. However, given that this framework will only apply in England, clinical managers who are registered with us in Scotland, Wales, and Northern Ireland will not benefit from this.

Where fitness to practise concerns are raised about clinical managers who are also registered healthcare professionals, they may already be subject to fitness to practise investigation by their professional regulator (where the concerns meet the threshold for investigation). Comparable fitness to practise proceedings will need to be established by the new regulator for those managers (clinical and non-clinical) that are deemed to be in scope for regulation.

While the notion of dual regulation of clinical managers is not insurmountable, and does already apply (although dual registration is not mandatory) for maxillofacial surgeons, public health specialists, and doctors working in cosmetic medicine, the higher volume of clinical managers may require more formal arrangements for the joint handling of concerns about their fitness to practise. We would be happy to discuss this with you further.

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

1. They should hold dual registration with both their existing healthcare professional regulator and the regulator of managers
2. 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

3. They should only hold registration with an existing healthcare professional regulator that will determine any leadership and managerial competencies
4. Don’t know

Don't know.

This would depend on the standards and code of conduct that you want to adopt, and how far these are aligned with guidance held by existing professional regulator But as we note above, while dual regulation already exists for oral and maxillofacial surgeons, public health specialists, and doctors working in cosmetic medicine, it is not mandatory.

Thought will need to be given to how dual regulation would work in practice to avoid duplication but provide consistency among managers who are registered with different professional regulators. It is possible for example that thresholds for referrals or the wording of standards may differ between professional regulators. This could potentially result in different outcomes for manager if these are not aligned.

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.

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

Agree.

If regulation is deemed to be necessary, then we would support a phased approach to its introduction.

A potential pathway to statutory regulation could be by through the establishment of a voluntary accredited register, with parallel work undertaken to develop professional standards and the necessary supporting education and training infrastructure. Once these pillars have been established, more evidence will be available to assess whether progressing to statutory regulation is necessary.

Thought will also need to be given to the transitional arrangements for bringing into regulation those within the cohort who are already practising while minimising any disruption to their ability to perform their duties. For example, whether there would need to be a set date by which those practising need to join a new register, or if those already practising would need to meet any new qualification requirements.

Duty of candour for NHS leaders

18. 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?

Agree.

We agree that all NHS leaders should have a professional duty of candour as part of the standards they are required to meet.

Registered healthcare professionals – including those in NHS leadership positions – already have a professional duty to be open and honest with patients and people in their care when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. In *Openness and honesty when things go wrong: The professional duty of candour* we also set out a duty for doctors, PAs and AAs to be open and honest with their employer, and to encourage a learning culture by reporting errors openly and honestly.

Furthermore, in our core guidance, *Good medical practice*, we say that: "if you have a formal leadership or management role, you must take active steps to create an environment in which people can talk about errors and concerns safely. This includes making sure that any concerns raised with you are dealt with promptly and adequately, in line with your workplace policy and our more detailed guidance on *Raising and acting on concerns about patient safety" (paragraph 76).*

We believe that a professional duty of candour is fundamental to good patient care and should therefore equally apply to all individuals in NHS leadership positions, regardless of whether they hold a clinical or non-clinical role.

Consideration should also be given to whether a professional duty of candour is something that could be applied using terms of employment rather than as a regulatory intervention.

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

Don't know – this depends on how 'NHS managers', for the purpose of the new regulatory regime, is to be defined. Once that has defined, every manager that makes up this cohort should be subject to the professional duty of candour (in the same way that all registered doctors, PAs and AAs are subject to our existing duty).

20. **Do you agree or disagree that NHS leaders should 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?**

See below.

21. **If you agreed, which categories of NHS managers should the statutory duty of candour apply to? (Select all that apply)**

N/A

NHS leaders' duty to respond to safety incidents

22. **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?**

23. **If you agreed, which categories of NHS managers should this apply to? (Select all that apply)**

24. **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?**

We have combined our responses to the questions relating to NHS leaders' duty to respond to safety incidents since, as we understand them, they all relate to a proposed statutory duty for individual NHS leaders.

We neither agree nor disagree with these proposals as there is insufficient detail about how these statutory duties will be enforced.

We note that one of the questions asks whether individual NHS leaders should 'be held accountable for' meeting a duty to ensure that the existing organisational duty of candour is correctly followed in their organisation. However, there is not further detail on what form this accountability would take. We are aware, for instance, that previous proposals for a statutory duty of candour for individuals (as recommended by the Hyponatraemia Inquiry in Northern Ireland) have suggested a threat of criminal sanctions for non-compliance. If the Department is proposing criminal sanctions for individuals, we think it is important to consider some risks associated with this. These risks include:

- While the details of the duty suggested by the Department may be slightly different to previous proposals, we have highlighted before how the threat of individual criminal sanctions for failures in candour could work against the culture of openness that we need in healthcare. A culture of fear, particularly a fear of the consequences of being candid, may be a strong influencing factor in decision-making. The introduction of individual criminal sanctions for failures in candour could potentially add to a climate of fear, driving staff to weigh up the perceived personal risks to them of disclosing

information (e.g. fear of litigation, or being scapegoated) versus the perceived risks of not doing so (e.g. fear of criminal prosecution).

- Leadership roles becoming less attractive as a career choice because of the level of exposure to potential criminal sanctions.

Additionally, a more general risk to be considered when creating new statutory duties for individuals is the potential to create confusion by introducing new legal duties in addition to existing professional duties. If a new statutory duty were to be introduced, investment in programmes to raise awareness amongst those affected by the duty would be needed.

We are unable to provide a detailed response to the suggestion of a statutory duty for managers to record, consider and respond to any concern raised (or to ensure that existing processes in place for this are followed) without understanding how the proposed duties would be enforced. Notwithstanding this, although our current guidance does not use the words 'record, consider and respond', it is again relevant to note that paragraph 76 of our core guidance, *Good medical practice*, states the following:

> *76 If you have a formal leadership or management role, you must take active steps to create an environment in which people can talk about errors and concerns safely. This includes making sure that any concerns raised with you are dealt with promptly and adequately, in line with your workplace policy and our more detailed guidance on Raising and acting on concerns about patient safety.*

As indicated in that paragraph, we also provide more detailed guidance for our registrants in *Raising and acting on concerns about patient safety*.

But as we note above, consideration should also be given to whether these duties could be simply attached to designated roles within NHS organisations, perhaps through terms of employment, rather than introduced as part of a regulatory framework.