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

(d) Extending the concept of the FPPT to Board level directors of commissioners and appropriate NHS Arms' Length Bodies (ALBs).[6]

(e) Setting up a body which has the power to bar directors where serious misconduct is proved to have occurred. We have suggested that this body be called the Health Directors' Standards Council (HDSC) and that it should have the powers to investigate, require the production of information and, following a fair hearing, to bar directors from director level appointments in the health service;

(f) Requiring the identification and definition of what is regarded as 'serious misconduct' justifying barring. This should focus upon deliberate or reckless but not inadvertent behaviour. Apart from obvious misconduct such as dishonesty and crime, we think there should be a focus upon behaviour which suppresses the ability of people to speak up about serious issues in the health service, whether by allowing bullying or victimisation of those who 'speak up' or blow the whistle, or by any form of harassment of individuals. There should be a focus on discouraging behaviour which runs contrary to the duty of candour, so any deliberate suppression or falsification of records or relevant information should be regarded seriously. Further, serious misconduct should include reckless mismanagement which endangers patients;

(g) Providing that 'normal' disciplinary and performance issues are still dealt with at Trust level. Serious misconduct should first be considered at Trust level, provided the relevant director is still employed at the Trust where that misconduct is said to have occurred, but, where it occurred elsewhere, the HDSC should have power to investigate and make determinations. The HDSC should be able to receive referred complaints from organisations and individuals but, in the case of complaints by individuals, there must be a sift so that before a complaint goes forward it must have a reasonable prospect of demonstrating serious misconduct. There should be a time bar in relation to 'historic' misconduct;

[6] See appendix 2

courses undertaken; full references; appraisals; upheld grievance and disciplinary findings. The database should also hold information about any criminal records checks, DBS checks[58] as well as any information about any NHS Protect investigations as well as fitness checks for Directors with both Companies House and the Charities Commission.

8.18 This is all information necessary to give a picture of the director concerned and employers and prospective employers ought to be able to access this information with ease. A central database would help to build the available picture and we believe would become a valuable resource to NHSI and to Trusts. The information held should be protected from Freedom of Information requests but should be accessible under a Data Subject Access Request by the individual to whom the records relate.

8.19 We have considered various organisations which could hold such a database but the most obvious place is within the NHSI who have indicated a willingness to do so. We have already prefaced this in Chapter 5 – NHSI.

Settlement agreements

8.20 Settlement agreements are fortunately or unfortunately very much part of the fabric of the NHS and are difficult to shift. We heard mixed views and were encouraged by some to make another attempt to ban them within the NHS. We do not think that would be right as there are many circumstances where for one reason or another, an individual ought to move on from a particular employment and a formal disciplinary hearing is inappropriate. It is right to say that a settlement agreement is sometimes used in order to avoid inevitable disciplinary proceedings, but we would hope that is much rarer than other legitimate reasons.

8.21 The real issue with settlement agreements however, is not necessarily the agreement itself, but the agreement as to the nature of the reference that follows the director out of one employment and into another. A settlement agreement ought not to be able to prevent a reference from being full, open and honest.

References

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

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

13. Recommendations

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

Recommendation One

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

13.1.1 In order to assist the effectiveness of Boards and Board directors and to encourage people within the service to consider Board posts, we recommend that NHSI should, in consultation with other bodies such as the NHS Leadership Academy and the Academy of Medical Royal Colleges, define, design and set high level core competencies which must be met by any person holding or aspiring to a directorship post (including Interim directors and NEDs[64]) in a Health Trust. Whether or not a director meets the requirements of Regulation 5 (3)(b) should be assessed against the identified competencies.

13.1.2 We recommend that the high-level core competencies should be embodied in a schedule to the Regulations and that further guidance should be issued when appropriate by NHSI to set out in detail the competencies to be met by every Health Trust Board Director and equivalent post;

13.1.3 We recommend that the required high-level core competencies relevant to directors should include knowledge and a general understanding of the following, no matter what role is undertaken:

- Board governance;
- Clinical governance;
- Financial governance;
- Patient safety and medical management;
- Recognising the importance of information on clinical outcomes;

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

- Responding to serious clinical incidents and learning from errors;
- The importance of learning from whistleblowing and 'speaking up';
- Empowering staff to make autonomous decisions and to raise concerns;
- Ethical duties towards patients, relatives and staff;
- Complying and encouraging compliance with the duty of candour;
- The protection, security and use of data;
- Current information systems relevant for health services;
- The importance of issues of equality and diversity both within the hospital in workforce issues and in relation to appointments to the Board; and
- The importance of complying on a personal basis with the Nolan principles.

13.1.4 We recommend that, as part of Trusts' ongoing responsibility to assess the competency of each member of the Board or those applying for a directorship post, Trusts ensure any necessary training is undertaken by Board members where gaps in competency have been identified.

13.1.5 We recommend that when ensuring compliance with Regulation 5 (3) (b) Trusts must have regard to the core competencies listed in the schedule and to any guidance issued by NHSI.

13.1.6 We recommend that the CQC should, during the 'Well-Led' inspection, review the evidence, including sampling appraisals in respect of the directors, to ensure that they are currently able to meet the core competencies, have regular appraisals and are up to date with personal development plans.

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

Recommendation Two

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

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